Division of Substance Abuse and Mental Health

2005 Annual Report on Public Substance Abuse and Mental Health Services in Utah

"I hope, therefore I can recover"

-Voices of Consumers pg. 89

State of Utah
Department of Human Services

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DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2005
Annual Report

Mark I. Payne, Director
Division of Substance Abuse
and Mental Health
Department of Human Services
120 North 200 West, Suite 209
Salt Lake City, UT 84103

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STATE OF UTAH

DEPARTMENT OF HUMAN SERVICES
BOARD OF SUBSTANCE ABUSE & MENTAL HEALTH

December 2005

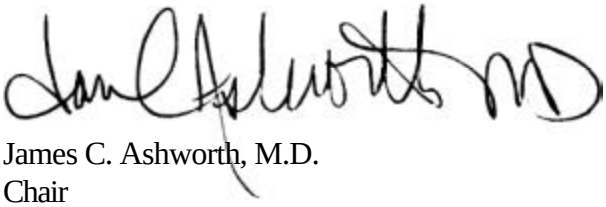
On behalf of the Utah State Board of Substance Abuse and Mental Health, it is my pleasure to present you with the 2005 Annual Report on Public Substance Abuse and Mental Health Services in Utah.

We appreciate the work that has gone into this report and we hope you will find it valuable. This report outlines the efforts of the mental health and substance abuse system for the past year. It identifies some of the initiatives, outcomes and challenges that we face. We encourage you to read the report and become familiar with what is happening in your own community and invite you to take an active role in making your community stronger and healthier.

We welcome your comments or suggestions for future editions of this report or for ways to improve our programs and services. You can contact the Division with your input at (801) 538-3939 or by e-mail via the Website at dsamh.utah.gov.

Respectfully,

UTAH BOARD OF SUBSTANCE ABUSE AND MENTAL HEALTH



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Division of Substance Abuse and Mental Health

MARK I. PAYNE
Director

December 2005

We appreciate this opportunity to share this Annual Report for Fiscal Year 2005. We hope the report will be helpful as you review the efforts being made throughout the system in providing treatment to Utah's citizens who have involvement with substance abuse and mental health services.

There have been many changes at the Division of Substance Abuse and Mental Health. We have reorganized our Division to assure that the goals of both substance abuse and mental health are achieved. Additionally, there are many co-occurring issues that require the joint efforts of all of our staff.

We recognize the significance of the work and services delivered to individuals through the local substance abuse and mental health system throughout the state. We thank all of the dedicated staff, advocates and volunteers who make a difference in the lives of the people and communities we serve.

Our main theme at the Division will focus on "Hope and Recovery." The Division's key principles are: 1) strengthen partnerships with consumers and families through a unified state, local and federal effort, 2) provide quality programs that are outcome focused and centered on "Recovery," 3) enhance education that will promote understanding and treatment of substance abuse and mental health disorders, and 4) demonstrate statewide leadership which meets the needs of consumers and families.

As we work towards "Recovery," we will be focusing on prevention and treatment efforts for adults and youth, utilizing the quality programs and services that are available throughout the system.

Sincerely,

Mark I. Payne, LCSW
Director

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About Utah's Public Substance Abuse and Mental Health System

Division of Substance Abuse and Mental Health (DSAMH)

DSAMH is the Single State Authority for public substance abuse and mental health programs in Utah, and is charged with ensuring that prevention and treatment services are available throughout the State. As part of the Utah Department of Human Services (DHS), DSAMH receives policy direction from the State Board of Substance Abuse and Mental Health, which is appointed by the Governor and approved by the Utah State Senate. DSAMH contracts with the local county governments statutorily designated as local substance abuse authorities and local mental health authorities to provide prevention and treatment services. The Board of Substance Abuse and Mental Health and DSAMH provide oversight and policy direction to these local authorities.

DSAMH monitors and evaluates mental health services and substance abuse services through an annual site review process, the review of local area plans, and the review of program outcome data. DSAMH also provides technical assistance and training to the local authorities, evaluates the effectiveness of prevention and treatment programs, and disseminates information to stakeholders.

DSAMH supervises administration of the Utah State Hospital.

Local Authorities

Under Utah law, local substance abuse and mental health authorities are responsible for providing services to their residents. A local authority is generally the governing body of a county. There are 29 counties in Utah, and 13 local authorities. Some counties have joined together to provide services for their residents. By legislative intent, no substance abuse or community mental health center is operated by the State. Some local authorities contract with community substance abuse centers and mental health centers, which provide comprehensive substance abuse and mental health services. Local authorities not only receive state and federal funds to provide comprehensive services, they are also required by law to match a minimum of 20% of the state general funds.

Website

The website (dsamh.utah.gov) is filled with information about substance abuse and mental health prevention and treatment. The Frequently Asked Questions section is updated as new questions and information are available. For example, a link to find treatment (findtreatment.samhsa.gov) provides the user with a list of all treatment facilities in an area. This is a national list that can be used to find treatment not only in Utah but also around the country.

Executive Summary

This Annual Report of the Utah Division of Substance Abuse and Mental Health (DSAMH) provides examples of the efforts and outcomes of the statewide system for treating people with substance abuse addictions and those with mental illnesses. Our outcomes continue to support the following: 1) prevention and treatment do work, 2) providing prevention and treatment is cost effective and 3) prevention and treatment help preserve families.

Throughout the substance abuse and mental health system, people's lives are improved and families become more functional. This is most effectively accomplished through prevention or early detection of problems, followed by effective treatment. The Division will continue to focus on developing a system that is consumer and family driven resulting in a life in the community for everyone.

The role of DSAMH is to provide statewide leadership to assure that needs of consumer are being met. The Division monitors local programs delivered by the local authorities and oversees the Utah State Hospital. We report outcomes of the services provided and attempt to get services to all individuals who need treatment. Treatment is tailored to meet the needs of each individual and move them towards recovery.

DSAMH is committed to utilize resources in the most effective way and to help as many individuals as possible. We continue to work with key partners in our system to reduce stigma and normalize services to people with addictions and mental illness.

Throughout the year we will continue to share information and outcomes through our Website at dsamh.utah.gov.

The following pages of this introduction identify a critical issue regarding funding, which DSAMH is continuing to focus on. Federal funding, which has been decreased, has created barriers for individuals in accessing treatment or the type of services they may receive. Additionally, the treatment needs for individuals with co-occurring disorders have not been well identified, nor have interventions been integrated to meet the holistic needs of the individual.

Funding

In 2004, the U.S. Census estimated there are 2,389,039 people in Utah. Of these, approximately 262,794 experience a significant to extreme functional impairment and could be classified as seriously emotionally disturbed (SED) youth or severely and persistently mentally ill (SPMI) adults (Surgeon General's Report, 1999). Of the approximately 83,000 Utah SED/SPMI residents only 51% receive necessary mental health treatment.

This means that in the State of Utah approximately 49% of the residents in need of mental health services do not receive treatment.

Faces of the Unfunded

- Children in the second generation of extensive parental drug use, who are being raised by grandparents or are in foster care.
- Children experiencing the biological effects of prenatal alcohol and drug use that result in severe learning problems.
- Children who are living in poverty, are neglected or abused, or are in one of the 51% of Utah homes where divorce has occurred.
- Young adults between the ages of 18-25 who have mental illness and must deal with the effects of emotional, cognitive, and behavioral disorders.
- These are young adults with mental illness who desire to live their lives in as full and complete a way as possible. They have the same basic desires as other young adults: an education, a decent job, a place of their own, friends, and intimate relationships
- Young adults who are poor and homeless and rely on public services, yet are often neglected by the mental health service delivery systemhis neglect takes the form of an absence of appropriate housing, services, and programming designed with this population's particular clinical and developmental needs in mind.
- Adults who are the working poor, uninsured, homeless, unable to work, living in poverty, have Social Security Disability Insurance (SSDI), substance abuse problems, legal problems, dependants for whom they cannot care, and often have failed marriages.
- Adults who are prevented from receiving psychoactive medication as part of treatment because they have no insurance.
- Adults who, as a result of their mental illness, are dependent on others for food purchase or preparation; personal hygiene; transportation; financial management; living arrangements; and leisure management.
- Adults whose symptoms are in remission, but whose condition seriously deteriorates without continued mental health treatment and support.

Changes Resulting in Loss of Services

1. Medicaid

The primary avenue for mental health treatment in Utah occurs through local community mental health centers. Historically, these centers were able to use surplus revenues from all funding streams to provide mental health treatment to any community resident in need. In 2003, however, a dramatic change occurred when the Centers for Medicare & Medicaid Services embraced the Balanced Budget Act and declared all surplus Medicaid revenues could be used only for those clients with Medicaid. With the advent of this ruling, mental health centers throughout Utah have had to prioritize their targeted treatment populations. For many Utah residents, this led to premature discharge from treatment or to the inability to access services. As a result of this decline in treat-

ment service options, there has been a dramatic increase in the number of emergency and inpatient services.

2. Increased Cost of Service

Each year, as the State allocates funds for the mental health centers, the cost of providing services exceeds the cost-of-living adjustment attached to the general fund monies. This means that more general fund dollars are used for administrative costs and fewer dollars remain for treatment services.

What are the societal costs to reducing the provision of needed treatment?

1. Cost Shifting

As mental health centers find themselves unable to provide services to people in need, would-be consumers find themselves in jails, hospital emergency rooms, detention centers and homeless shelters. Please see the graph on the following page, which shows the dramatic increase in emergency and inpatient services as the traditional services provided to SPMI/SED consumers were withdrawn.

2. Poor Care

Services provided by emergency rooms, jails and other facilities often lack personnel trained to treat people who have serious mental illness needs. Thus, providers find themselves feeling stressed, inadequate and resentful of the system for "dumping" clients in inappropriate places, with inadequately trained providers.

3. Lower Grades, Graduation Rates, and Lower Attendance at Post-Secondary Schools

Approximately 36% of severely emotionally/ behaviorally disturbed children/youth graduate from high school (compared to 54% for all disability groups). Additionally, approximately 50% of SED children and youth have failing grades. Less than 18% attend post-secondary school compared to 23% for all disability groups. (Source: The Annual Report to Congress on the Implementation of IDEA, U.S. Department of Education, 1992.)

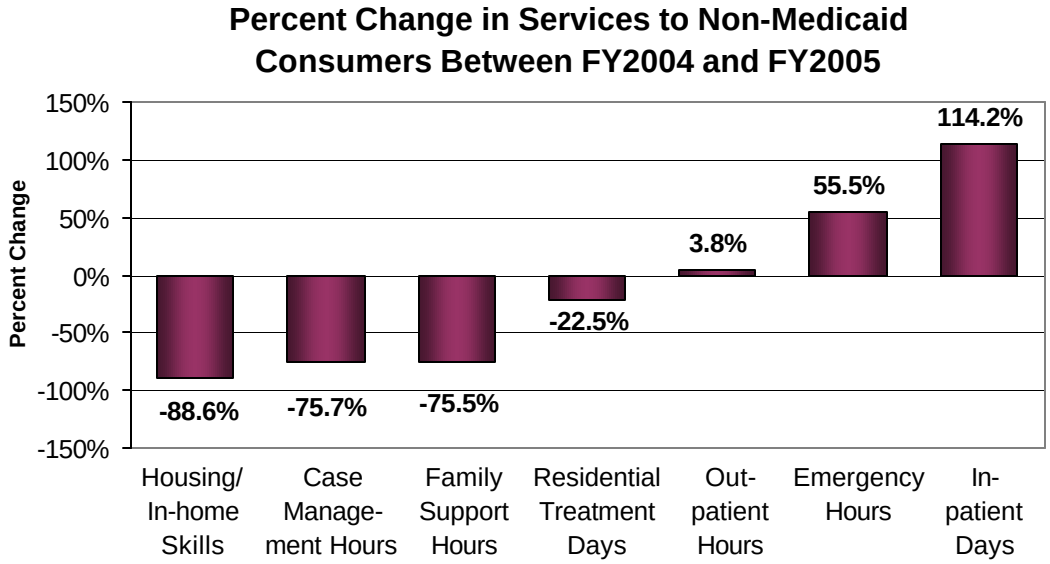
4. Increased Human Suffering

As consumers are unable to obtain the resources needed to prevent regression and decompensation, an increasing number of human beings - consumers, family members, and other care providers - suffer.

Recommendations from the Division of Substance Abuse and Mental Health

- Increase efforts to heighten awareness of mental health issues and obtain increased funding
- Work toward parity so that more people are able to access mental health services
- Work with allied agencies to maximize efficiency in funding opportunities and reduce duplicate services
- Through Utah's Transformation of Child and Adolescent Network (UT CAN), provide consultation and technical assistance to communities as they try to modify existing infrastructures to accommodate complex community priorities
- Encourage the development of more school-based mental health servcies

The following graph depicts changes in services to non-Medicaid consumers between fiscal years 2004 and 2005. Housing/in-home skills training, case management hours, family support hours, and residential treatment days decreased while outpatient hours and emergency hours increased. This data supports the clinical observation that a withdrawal of services known for keeping people stable in the community parallels a sharp increase in expensive acute services.



Co-Occurring Disorders

Integrated Treatment for Clients with Co-occurring Disorders

Individuals said to have co-occurring disorders (COD) have one or more disorders related to the use of alcohol and/or other dugs of abuse, as well as one or more mental disorders. A diagnosis of co-occurring disorders is made when at least one disorder of each type can be established, independent of the other, and is not simply a cluster of symptoms resulting from the one disorder.

The National Survey on Drug Use and Health (NSDUH) reports that in 2002, four million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse. SMI is highly correlated with substance dependence or abuse. Among adults with SMI in 2002, 23.2% were dependent on or abused alcohol or illicit drugs while the rate among adults without SMI was only 8.2%. Among adults with substance dependence or abuse, 20.4% had SMI; the rate of SMI was 7% among adults who were not dependent on or abusing a substance.

Among adults who used an illicit drug in the past year, 17.1% had SMI in that year, while the rate was 6.9% among adults who did not use an illicit drug. Conversely, among adults with SMI, 28.9% used an illicit drug in the past year while the rate was 12.7% among those without SMI (OAS 2003b).

Both research and clinical practice confirm that people with co-occurring substance abuse and mental health disorders are a large part of the population referred to, or in need of, treatment. The research from Dr. Mark Regan, MD (psychiatrist of Village Inc., and noted author on mental health recovery) indicates that co-occurring substance abuse and mental health issues are present to the following degrees:

- Approximately 40% of mental health consumers in an average outpatient clinic
- Approximately 70% of mentally ill people visiting emergency rooms
- At least 80% in the homeless population
- Nearly 90% of mentally ill incarcerated people also have substance abuse issues

In addition, the National Mental Health Association reports: approximately 2/3 of incarcerated youth have co-occurring disorders, approximately 50% of substance abusing youth have ADHD, and nearly 1/3 of incarcerated youth have a mood or anxiety disorder. Furthermore, the National Institute of Mental Health indicates that consumers with bipolar disorder are 14.5% more likely to develop a co-occurring substance abuse disorder and people with schizophrenia are 10.1% more likely to develop a co-occurring substance abuse disorder.

In Utah, we struggle as do other states, in being able to collect data on co-occurring substance abuse and mental illness disorders. However, the Utah State Hospital (USH) has implemented a data collection system that clearly captures data indicating approximately 38% of the consumers at USH have co-occurring treatment needs.

The abuse of substances by a person with a mental illness contributes to: a worsening in symptoms, relapse and more frequent hospitalizations, social and behavioral problems, an increased vulnerability to suicide, homelessness, associated health risks (HIV, poor appetite, liver problems), and violent and unsociable behavior.

Individuals with co-occurring disorders typically experience multiple health and social problems and require services that cut across systems of care. Few have substantial resources or supports and no single system is equipped in resources, service capacity and training to provide quality treatment to this population (SAMHSA, 2002).

There are several factors that contribute to the inability of individual service systems to provide the full range of needed and appropriate services:

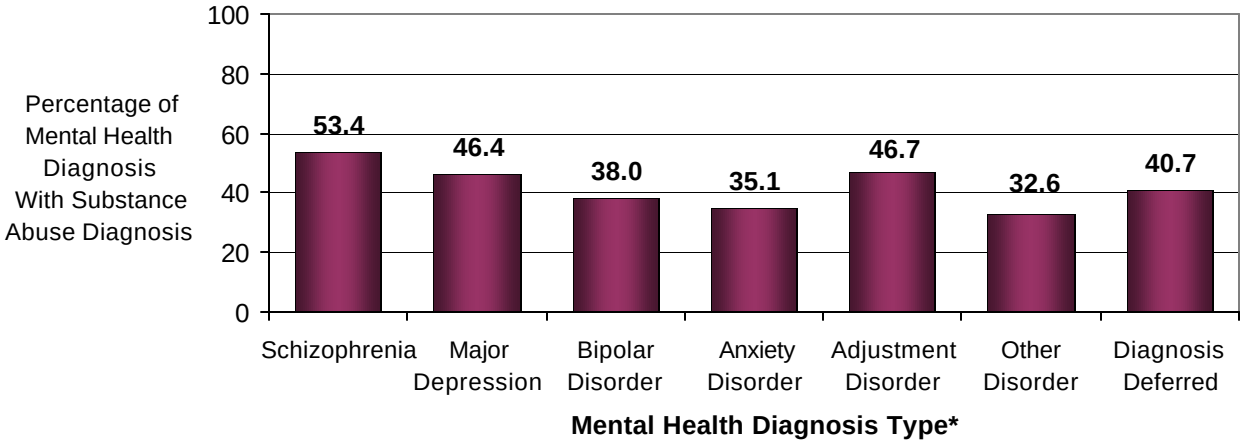
- Many local authorities do not have a combined mental health and substance abuse treatment system. Of those whose centers are combined, many do not have a strong co-occurring or dual diagnosis integrated treatment program.
- Few centers have staff who are dually trained in treating consumers presenting with both mental health and substance abuse needs.
- Difficulty obtaining accurate information on the numbers of individuals who are truly dually diagnosed. (Most third party payers require a primary diagnosis linked to the question: is this person being treated for substance abuse (SA diagnosis) *or* mental health (MH diagnosis) and force a choice between the two for payment; thus, reportable diagnoses are seldom listed in a co-occurring fashion.)
- A severely limited pool of both trained personnel and instruments to accurately and reliably assess for co-occurring disorders, especially at the onset of treatment. This issue is particularly relevant to adolescents as severe mental illness often first presents as a substance abuse treatment need and teenagers are reluctant to disclose information that may lead others to think they are "crazy."
- The most effective interventions are very expensive (e.g., drug court/drug board, multisystemic or functional family therapy).

Recommendations from the Division of Substance Abuse and Mental Health

- Adopt a change in philosophy. Programs treatings individuals with co-occurring disorders should be the *expectation*, not the exception, in the substance abuse and mental health system. Both disorders must be addressed as primary and treated as such. Recognition that an individual with a mental disorder is at increased risk for developing a substance abuse disorder and, conversely, that a person with a substance abuse disorder is at increased risk for developing a mental disorder.
- Promote better data collection to substantiate the need for additional resources to treat individuals with co-occurring disorders.
- Provide consultation and training for this issue.
- Recognize and provide incentives to those Local Authorities and/or practitioners who provide integrated care.
- Pursue the possibility of releasing a Request for Proposal to develop a Center for Excellence (augmented with Division funds) that would provide evidenced-based, integrated treatment for both adult and pediatric populations.

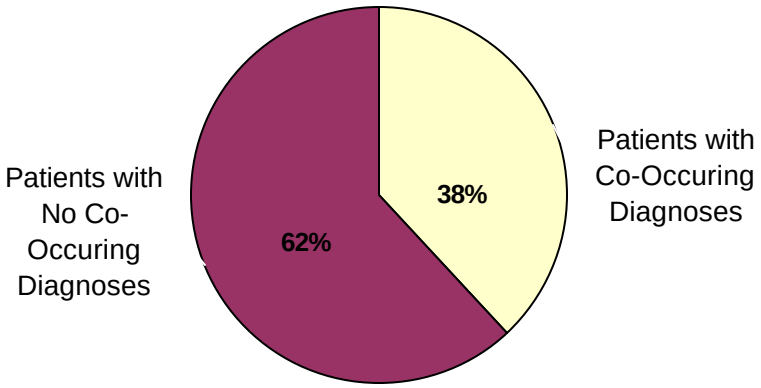
The following graph represents people served at the Utah State Hospital with co-occurring diagnoses. Of all patients served in fiscal year 2005 with a diagnosis of schizophrenia, 53% also had a substance abuse diagnosis. Some of these same patients may also have other co-occurring diagnoses (e.g., major depression, anxiety disorder, etc.).

Percentage of Co-occurring Mental Health and Substance Abuse Diagnoses for All Patients Served at USH
FY 2005



*Patients may have more than 1 diagnosis. This chart includes both admission and treatment diagnoses.

Percentage of Patients Served at the Utah State Hospital with Co-Ocurring Diagnoses



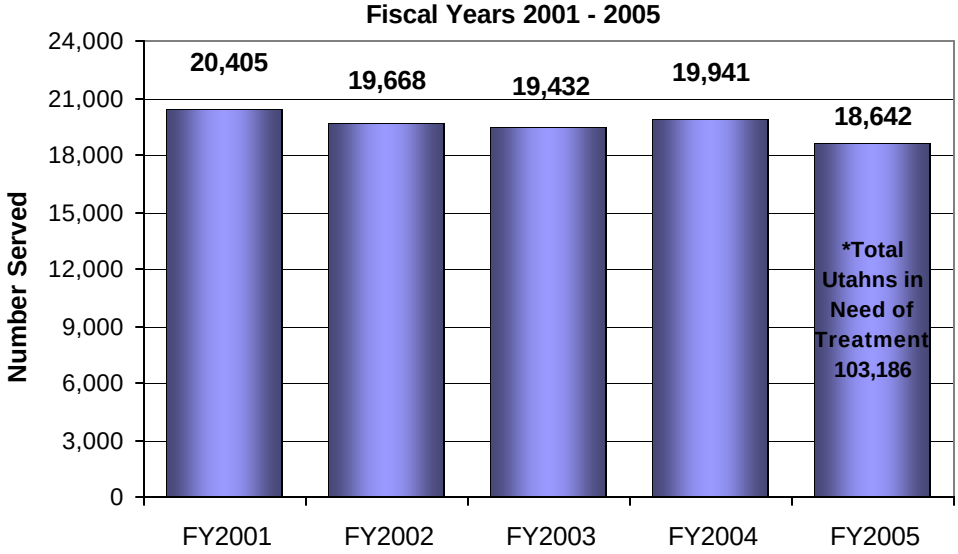
WHO DO WE SERVE

Total Number Served

The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities for fiscal years 2001 through 2005. The same is depicted for individuals in service within community mental health centers for fiscal year 1996 through fiscal year 2005.

Total Number of Individuals Served in Substance Abuse Services

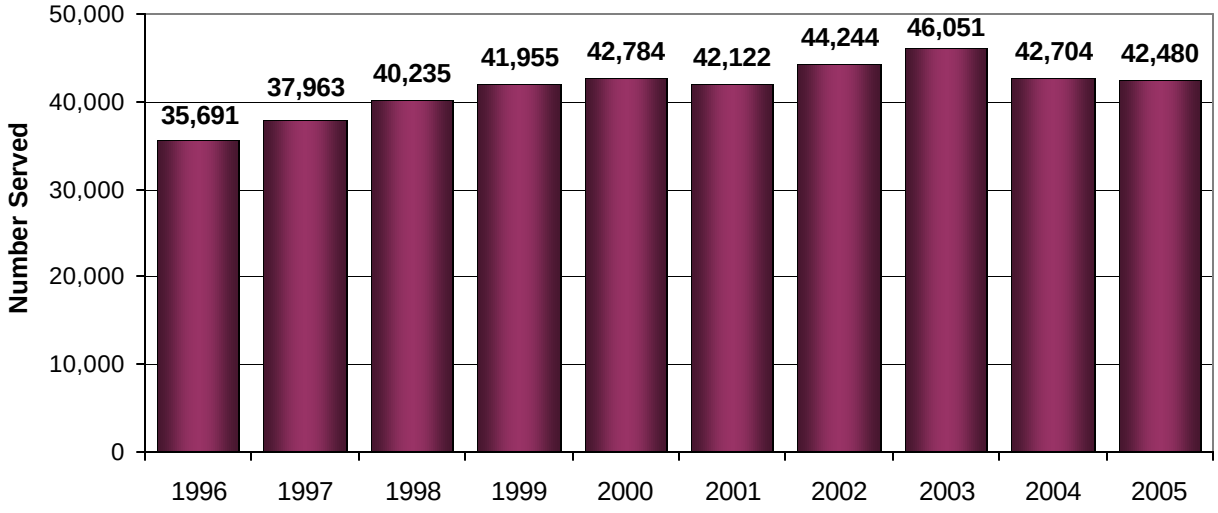
Fiscal Years 2001 - 2005



*** Taken from the 2000 State of Utah Telephone Household Survey Treatment Needs Assessment Project and the 2005 State of Utah Prevention Needs Assessment Survey**

Total Number of Individuals Served in Mental Health Services

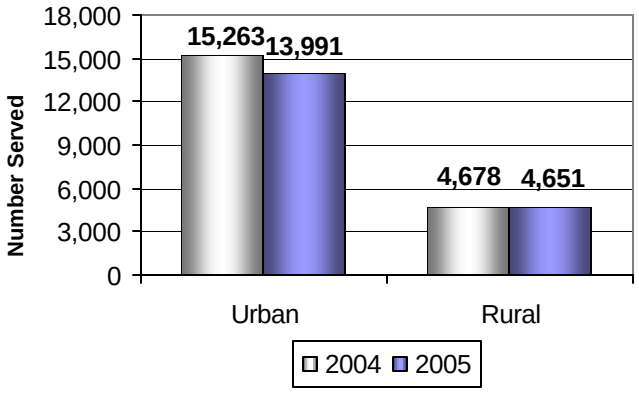
Fiscal Years 1996 - 2005



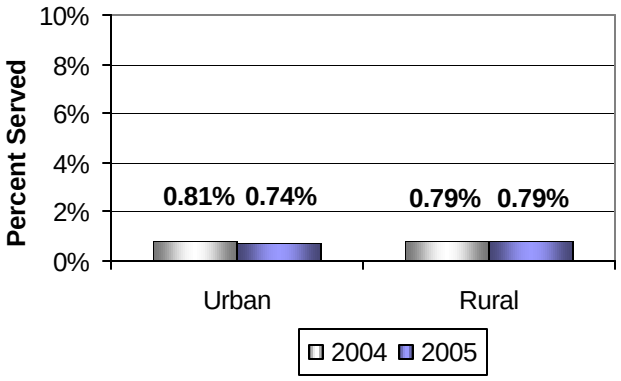
Urban versus Rural Areas

The following graphs show the total number of individuals served in urban versus rural communities and a percentage of the total population served for substance abuse and mental health.

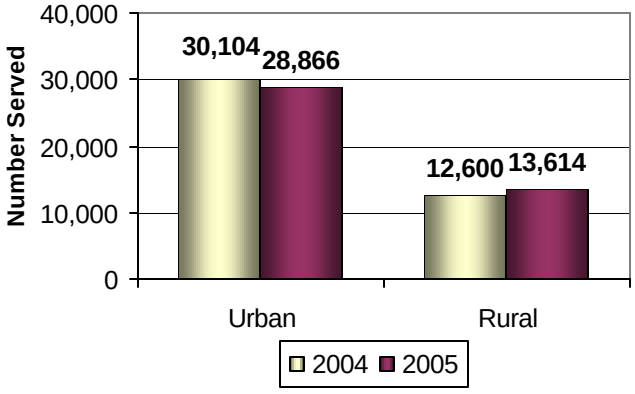
Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2004-2005



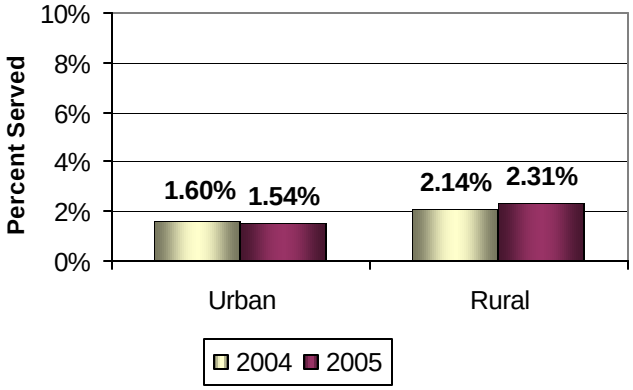
Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2004-2005



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2004-2005



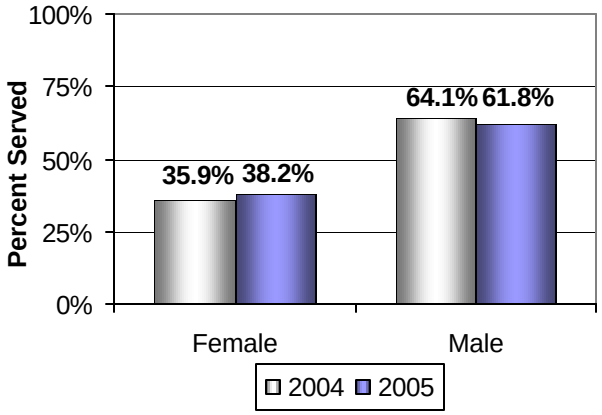
Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2004-2005



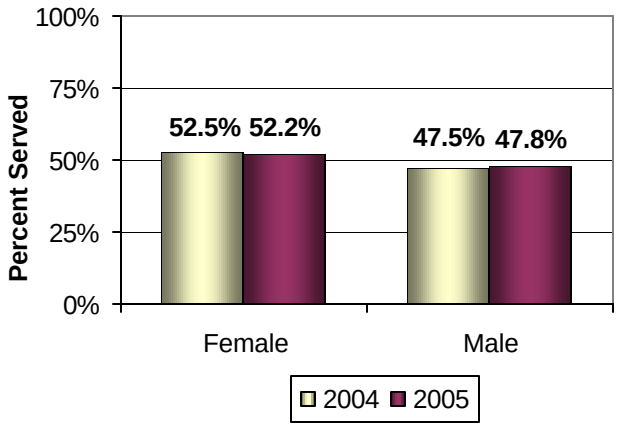
Gender and Age

The following figures show the distribution of services by gender and age for Substance Abuse and Mental Health services. There are significant differences between the substance abuse and mental health populations in both gender and age

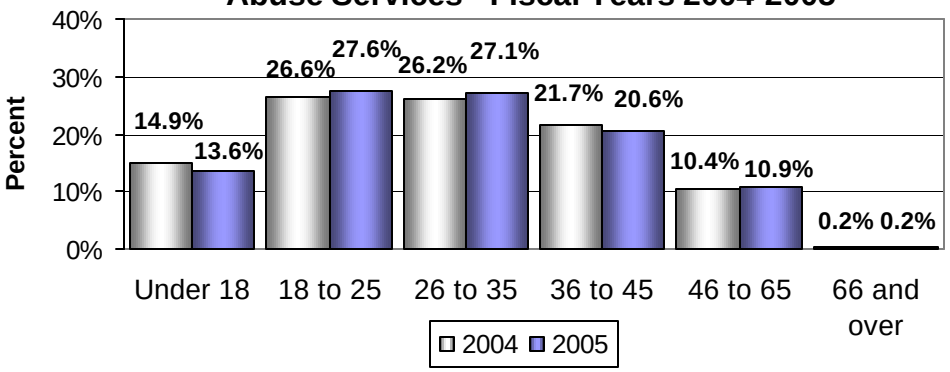
Gender of People Served in Substance Abuse Services - Fiscal Years 2004-2005



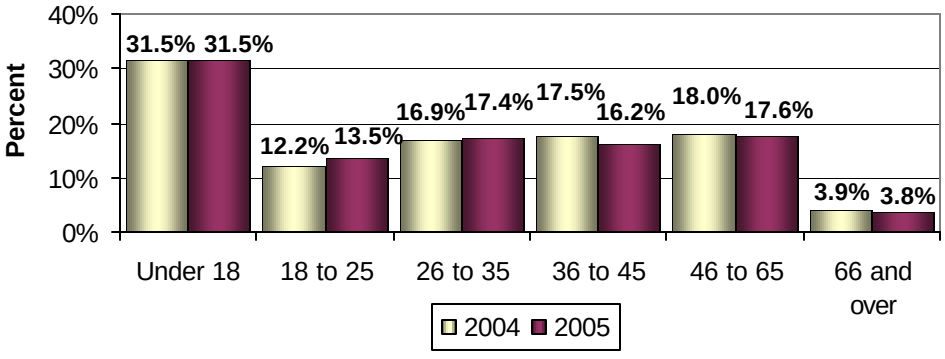
Gender of People Served in Mental Health Services - Fiscal Years 2004-2005



Age Grouping of People Served in Substance Abuse Services - Fiscal Years 2004-2005



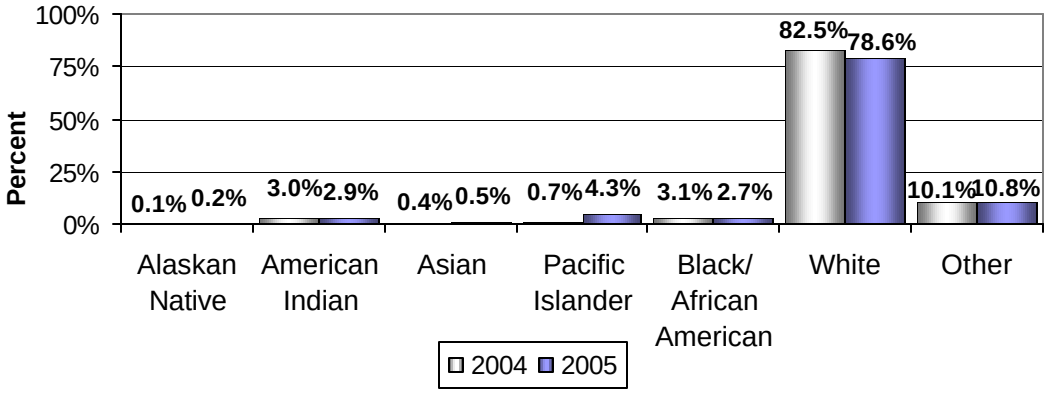
Age Grouping of People Served in Mental Health Services - Fiscal Years 2004-2005



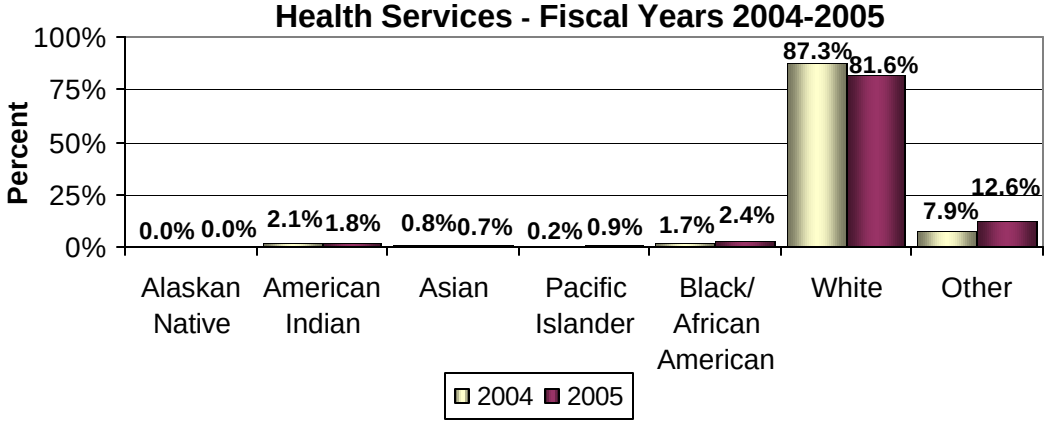
Race and Ethnicity

The graphs below report the distribution of the treatment population by race categories. There are no significant differences in race and ethnicity for the clients receiving substance abuse or mental health services. More detailed data on ethnicity categories are available for substance abuse clients than mental health clients.

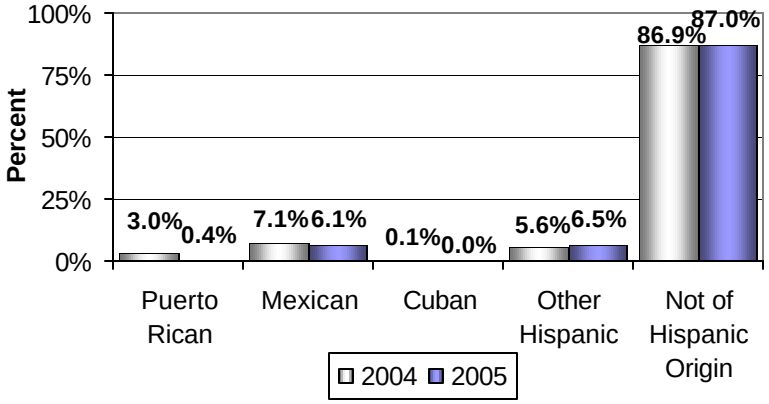
Race of People Served in Substance Abuse Services - Fiscal Years 2004-2005



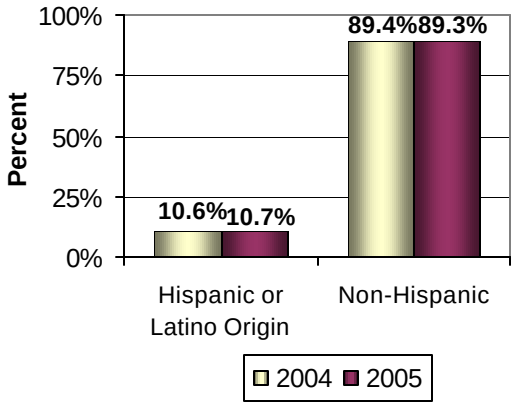
Race of People Served in Mental Health Services - Fiscal Years 2004-2005



Ethnicity of People Served in Substance Abuse Services
Fiscal Years 2004-2005



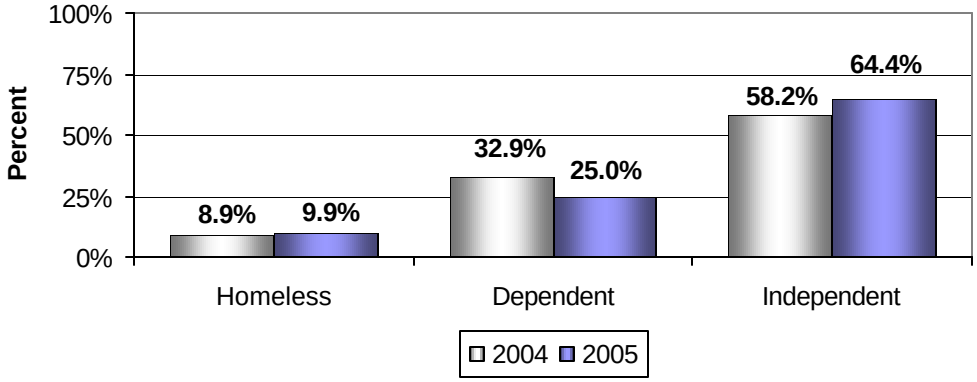
Ethnicity of People Served in Mental Health Services
Fiscal Years 2004-2005



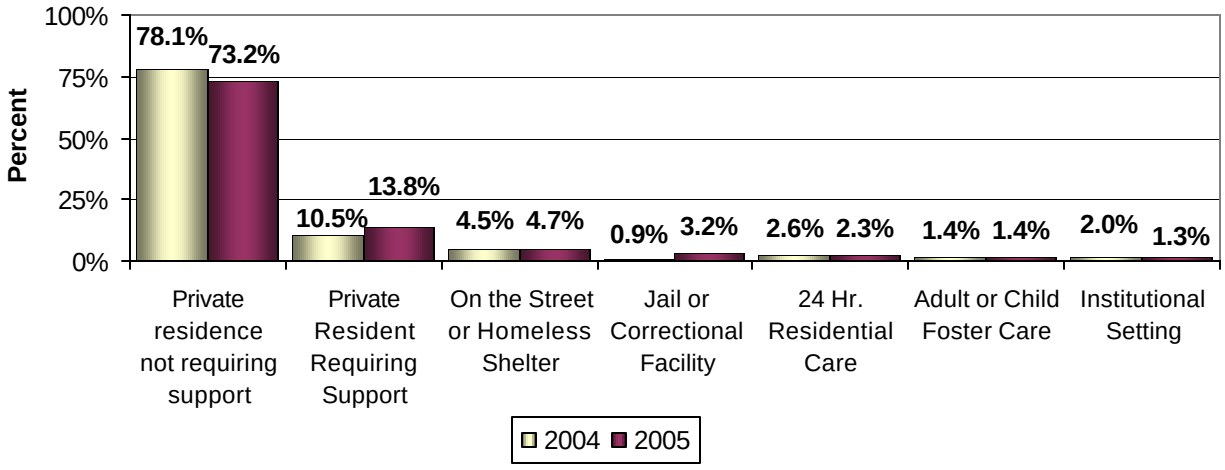
Living Arrangment at Admission

The following graphs depict the living arrangement at admission for substance abuse and mental health clients served in fiscal year 2005. By far, the majority of clients receiving substance abuse and mental health services are independent citizens at the time they enter treatment. More detailed data on living arrangment categories are available for mental health clients than substance abuse clients.

Living Arrangement at Admission of Adults Served in Substance Abuse Services - Fiscal Years 2004-2005



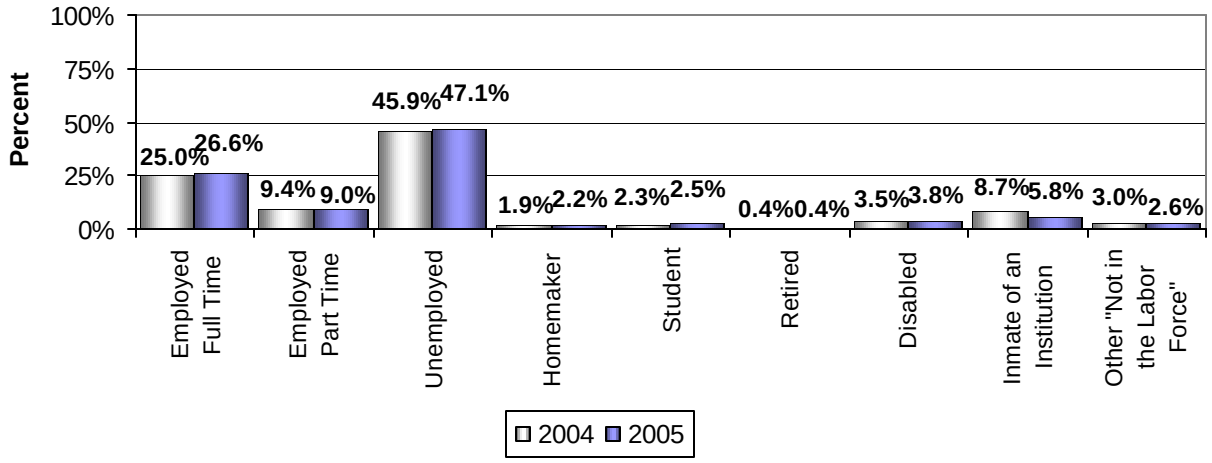
Living Arrangement at Admission of Adults Served in Mental Health Services - Fiscal Years 2004-2005



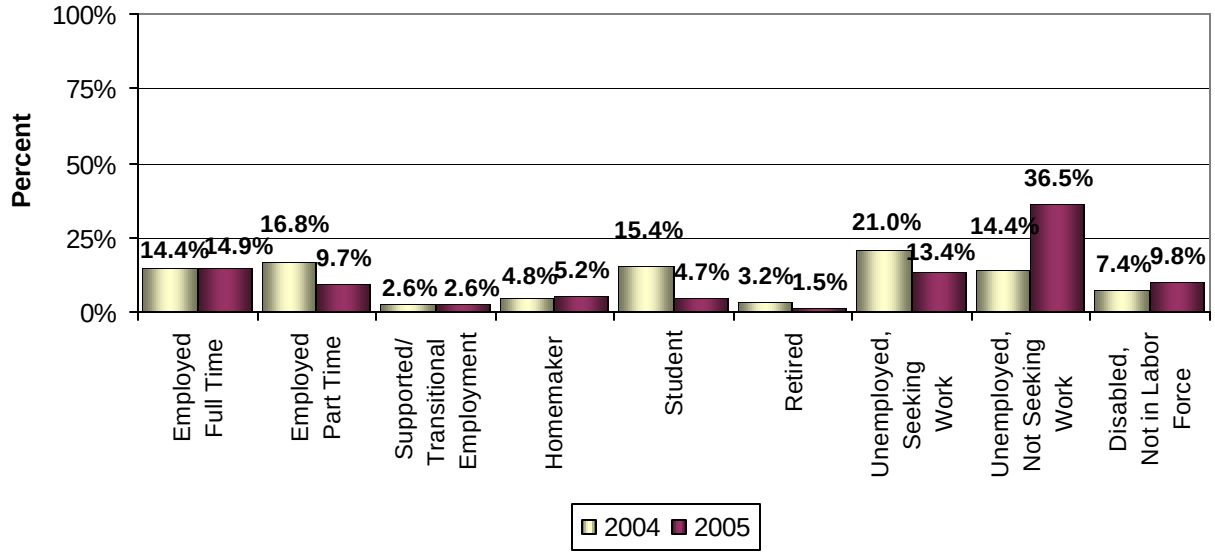
Employment Status at Admission

The following graphs show the employment status at admission for substance abuse and mental health clients served in fiscal year 2005. The categories for mental health clients are different than those for substance abuse clients.

Employment Status of Adults Served in Substance Abuse Services
Fiscal Years 2004-2005



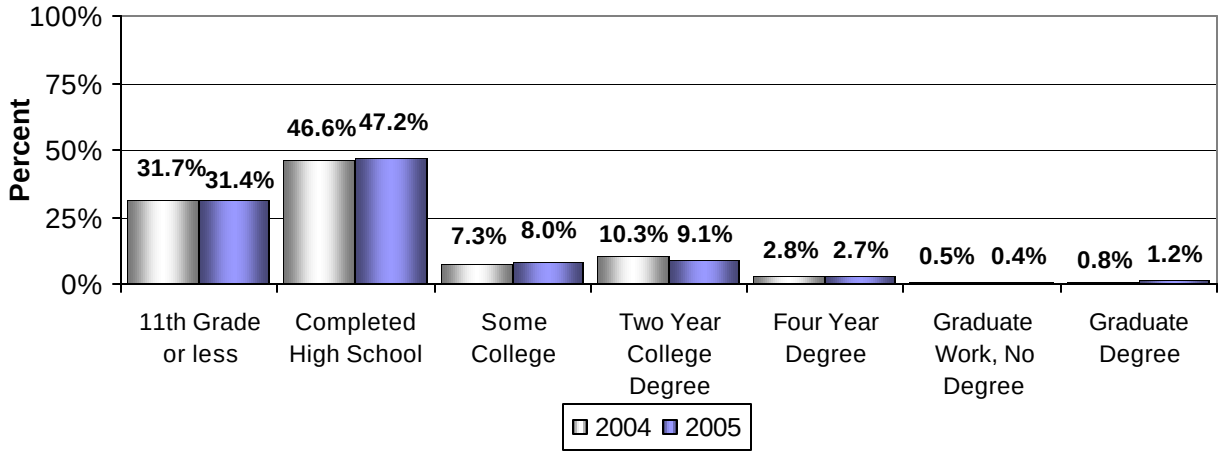
Employment Status of Adults Served in Mental Health Services
Fiscal Years 2004-2005



Highest Education Level Completed at Admission

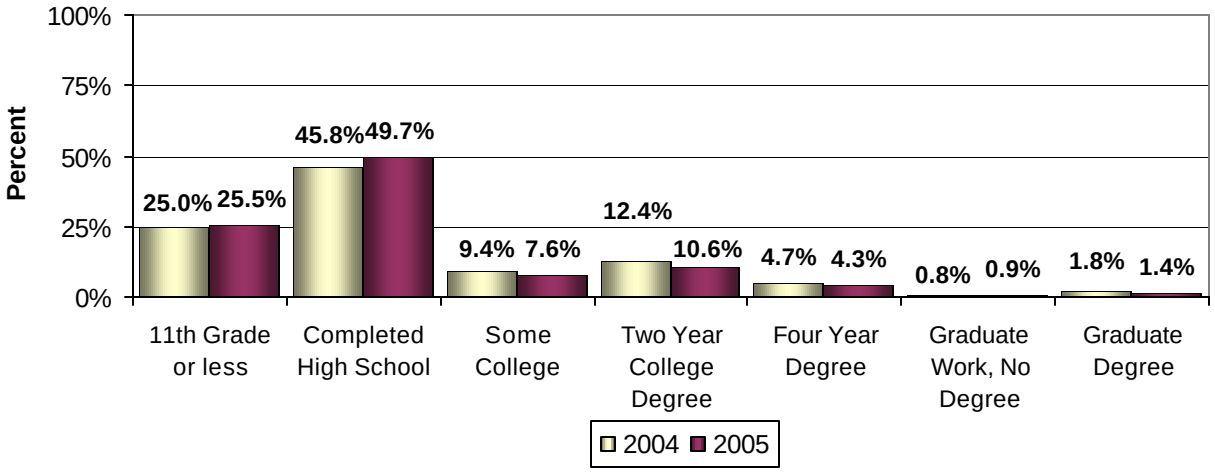
In fiscal year 2005, 68.6% of adults in substance abuse treatment statewide completed at least high school, which included those clients who had attended some college or technical training. Additionally, 13.4% of the population had received some type of college degree prior to admission. Still, over 31% had not graduated from high school.

Highest Education Level of Adults Served in Substance Abuse Services - Fiscal Years 2004-2005



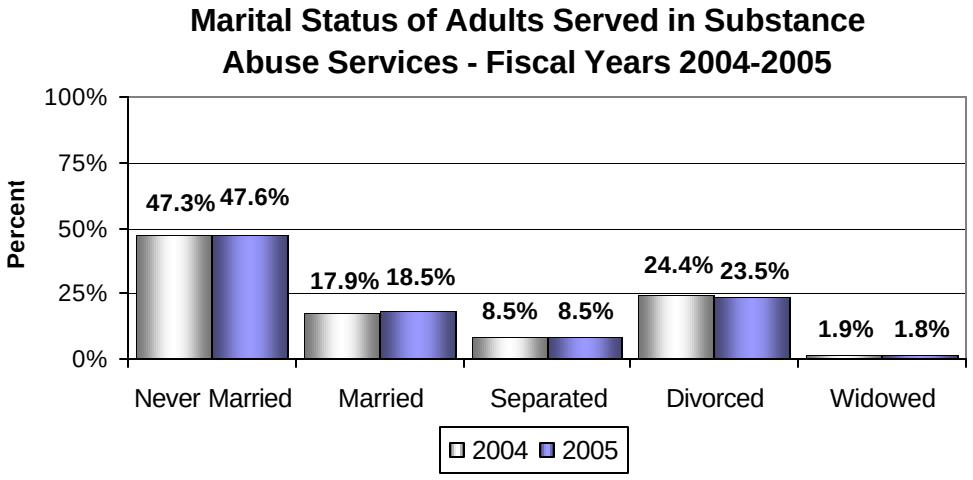
In fiscal year 2005, 74.5% of adults in mental health treatment statewide completed at least high school, which included those clients who had attended some college or technical training. Additionally, 24.8% of the population had received some type of college degree prior to admission. Still, over 25% had not graduated from high school.

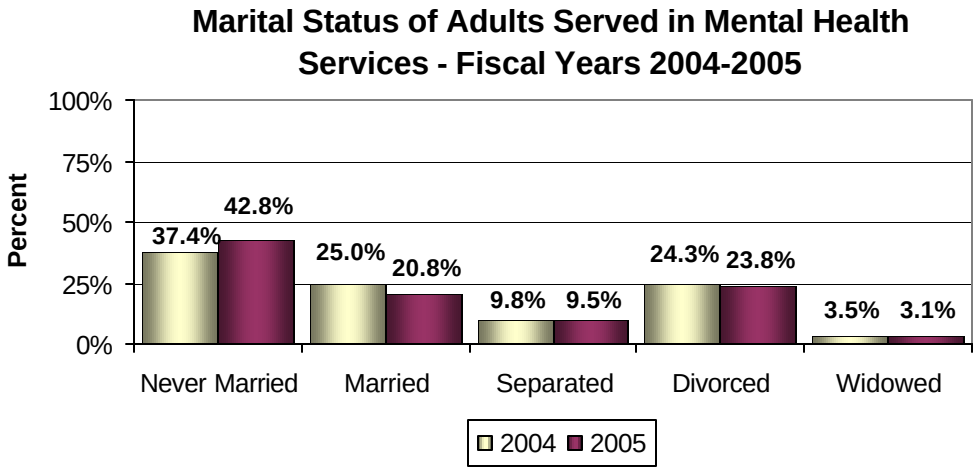
Highest Education Level of Adults Served in Mental Health Services - Fiscal Years 2004-2005



Marital Status at Admission

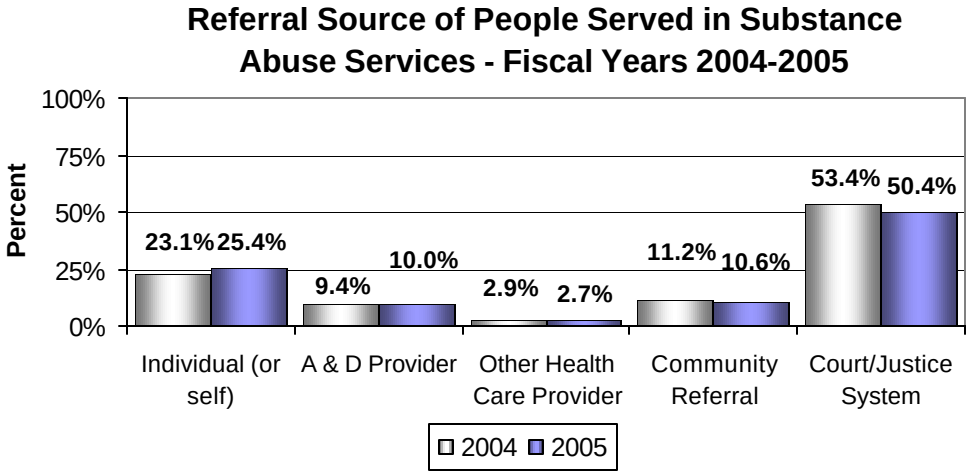
The following graphs show the marital status at admission for substance abuse and mental health clients served in fiscal year 2005.

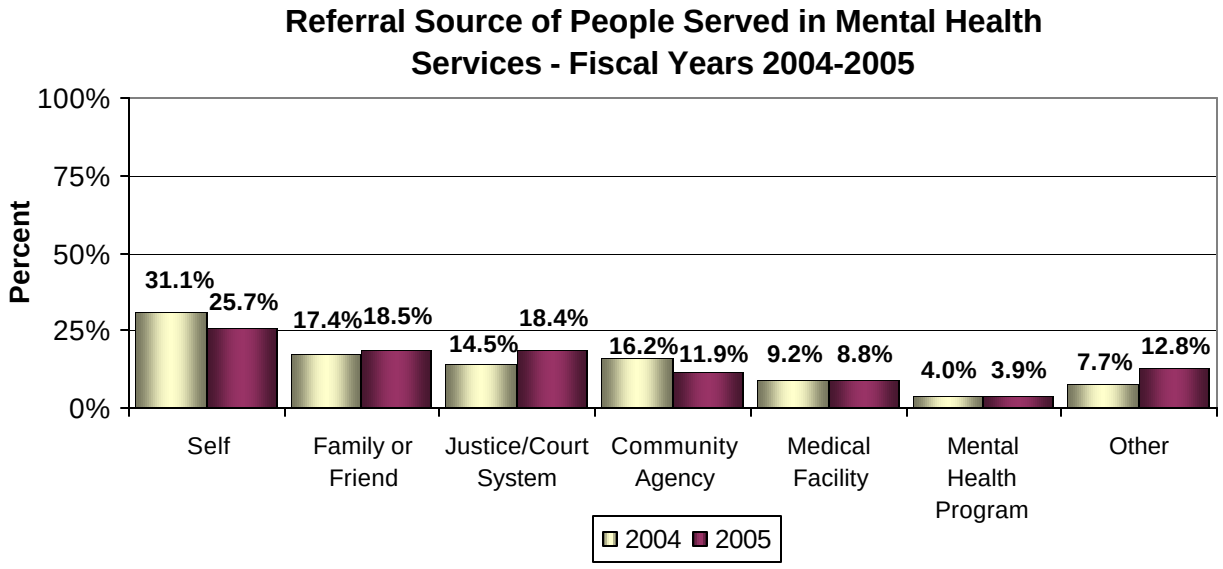




Referral Source

The individual or organization that has referred a patient to treatment is recorded at the time of admission. This source of referral into treatment can be a critical piece of information necessary for helping a patient stay in treatment once there; the "referral source" can continue to have a positive influence on the patient's recovery. The graphs below show the detailed referral sources for fiscal year 2005.





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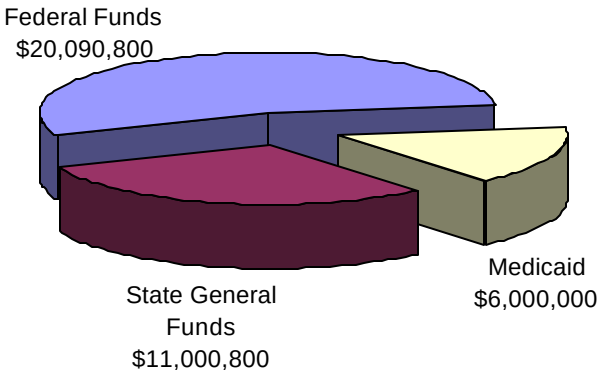
Source of Funding and Category of Expenses

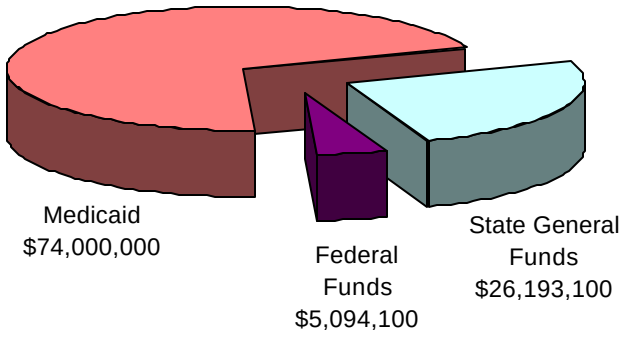
The Division's source of funding for the public substance abuse and mental health programs are State General fund and Federal funds. The Medicaid funding shown in these charts are estimates and funding is actually disbursed by the Department of Health. The Division receives funding from approximately ten Federal grants, which are identified in the charts as Federal funds.

Substance Abuse Services Funding
Fiscal Year 2005



***Total Funding: $37,091,600**

Mental Health Services Funding
Fiscal Year 2005

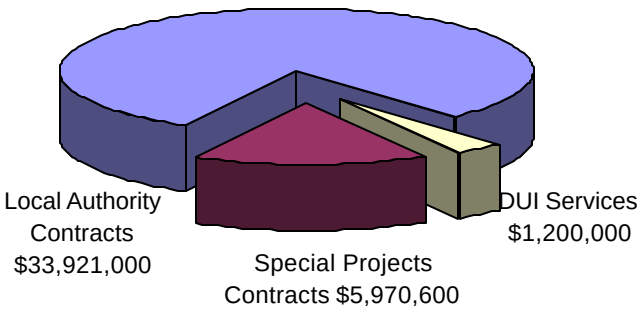


***Total Funding: $105,287,200**

*In addition, the counties are required to match a minimum of 20% of the state general funds.

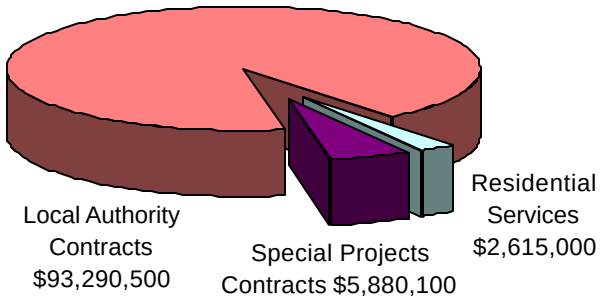
The funding identified above is allocated and identified in three categories. The majority of funding is expended within the Local Authority Contracts. This is where the Division allocates funding by a required formula, based on population and other factors. Special Project Contracts involve programs such as UT-CAN, RECONNECT, SIG-E, CIAO, etc., which are mentioned and discussed in this report.

Substance Abuse Services Expense Categories
Fiscal Year 2005



Total Expenses: $37,091,600

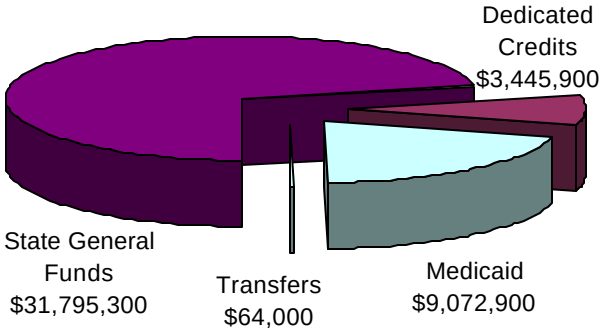
Mental Health Services Expense Categories
Fiscal Year 2005



Total Expenses: $105,287,200

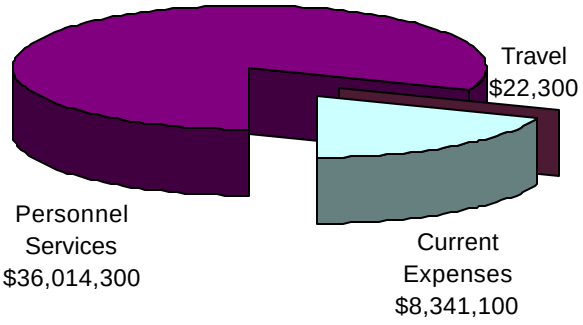
The Utah State Hospital is funded largely by general funds (approximately 76%). The remaining 24% of hospital revenue comes from Dedicated Credits and Title XIX Medicaid dollars. The Utah State Hospital's expenditures for personnel is 88% and the remaining 18% is for operational costs.

Utah State Hospital Funding
Fiscal Year 2005



Total Funding: $44,378,100

Utah State Hospital Expense Categories
Fiscal Year 2005



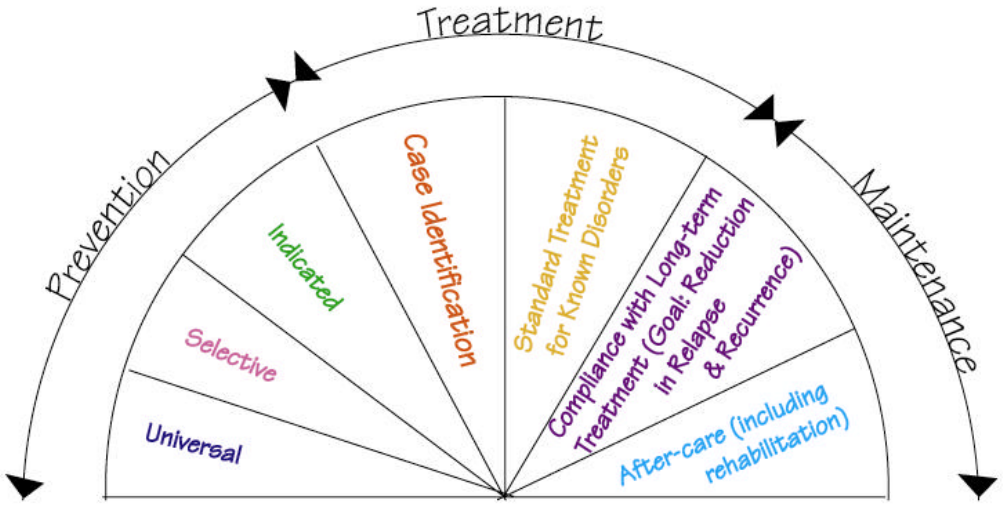
Total Expenses: $44,378,100

SUBSTANCE ABUSE PREVENTION

Substance abuse is a preventable behavior and addiction is a treatable disease. Like other diseases, the "risk factors" for substance abuse can be identified and mitigated in order to interrupt the development or progression of the addictive process. Similarly, "protective factors" buffer the impact of risk factors. The Risk and Protective Factor Model developed by Drs. David Hawkins and Richard Catalano at the University of Washington provides the foundation for all of Utah's prevention services. In determining what prevention services will be implemented in a particular community, a profile of the area's risk and protective factors is created utilizing data from various sources, including periodic surveys and archival indicators. Once the risk and protective factors for the area are identified, local planning bodies select prevention programs that are targeted at reducing risk and enhancing protection. Emphasis throughout the state is on using prevention programming that science has shown to be effective.

What Prevention Services are Available?

Substance abuse prevention services are provided throughout Utah by designated agencies within the State's 13 local substance abuse authority areas. In each local authority agency, a Prevention Coordinator oversees the planning, implementation, and evaluation of all substance abuse prevention services. A comprehensive continuum of prevention services is available to address populations in need. This comprehensive approach address needs across ages, cultures, and other populations based on experience with alcohol, tobacco, and other drugs.



Utah K-12 Prevention Dimensions Program

Prevention Dimensions is Utah's pre-kindergarten through 12th grade alcohol, tobacco, and other drug prevention education program. It consists of a scoped and sequenced curriculum for each grade level and an intensive teacher in service training component. DSAMH, along with the Utah State Office of Education and the Utah Department of Health, is a key partner in the development and implementation of Prevention Dimensions; local substance abuse authority agencies provide the teacher in-service training. DSAMH currently funds a rigorous evaluation of the curriculum that will lead to the program's designation as an "effective" science-based program in the near future.

State Incentive Cooperative Agreement (SICA)

In 2000, the Center for Substance Abuse Prevention (CSAP) awarded Utah a State Incentive Cooperative Agreement (SICA) - a three-year grant of $8.7 million, targeted at providing prevention services for 12-17 year olds. The purpose of SICA was to transform Utah's substance abuse prevention system by phasing out ineffective practices and moving toward implementation of science-based practices, policies, and programs that have been proven to work. Data gathered during this project show it as a success. Utah's local substance abuse authorities re-allocated prevention resources, reduced duplication of services, and are now providing more science-based programs. Utah's local substance abuse authority areas have undertaken comprehensive data collection, risk and protective factor identification, and effective program planning. All of the local authorities plan to maintain the community coalitions and partnerships they established during the SICA project.

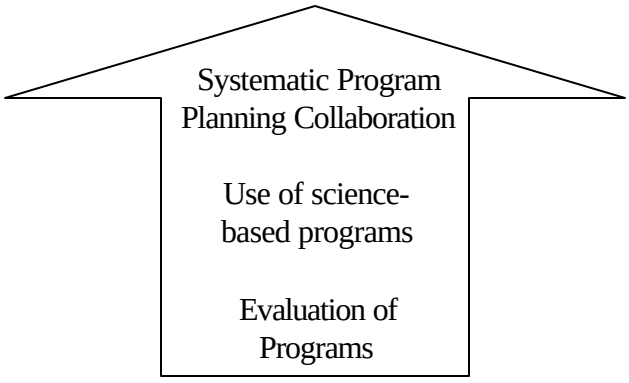
Number of SICA Programs by Category

Local Authority	Domains				Target Group			Prevention Category			Total**
	Community	Family	School	Individual/ Peer	Youth	Parents	Other Adults	Universal	Selective	Indicated	
Bear River	11	7	16	13	36	14	10	27	6	11	44
Central	6	1	8	10	17	2	4	9	7	6	19
Davis	6	14	6	24	30	14	5	17	10	13	43
Four Corners	7	0	3	9	16	4	4	10	3	3	16
Northeastern	1	5	2	14	16	9	3	10	6	6	20
Salt Lake	11	18	30	36	65	13	9	33	29	15	69
San Juan	8	9	12	11	16	11	6	13	6	4	22
Southwest	8	16	16	13	33	18	7	24	14	9	40
Summit	11	3	12	6	25	11	10	24	3	4	31
Tooele	10	10	15	17	28	14	11	29	7	4	37
Utah County	17	10	21	8	30	19	13	17	21	14	40
Wasatch Co.	9	1	15	2	21	4	5	14	8	8	26
Weber HS	14	10	26	36	56	16	6	39	23	23	67
Total*	119	104	182	199	389	149	93	266	143	120	**474**

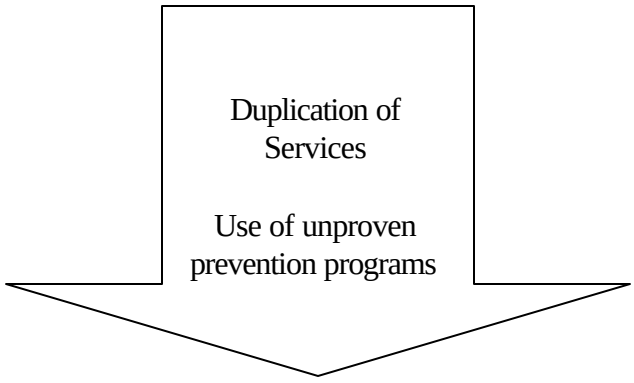
*Each program is counted multiple times in this row

**Total number of programs offered by each Local Authority

***Increased* as a result of SICA**



***Decreased* as a result of SICA**



Utah Prevention Advisory Council (UPAC)

In conjunction with the SICA and SIG-E grants, the Division of Substance Abuse and Mental Health developed a state-level advisory council to oversee substance abuse prevention efforts in Utah. The Council consists of representatives from most major agencies conducting prevention in Utah, with membership constantly growing as new partners are identified. The Council has created an "Interagency Cooperative Agreement for Substance Abuse Prevention in Utah," to be signed and supported by the Governor and the heads of all key agencies. The primary purpose of the council and the agreement is to ensure future coordination and collaboration of prevention efforts.

State Incentive Grant Enhancement (SIG-E) Higher Education Grant

The Division of Substance Abuse and Mental Health is managing a statewide grant focused on higher education issues, which includes all nine Utah public higher education institutions. The Center for Substance Abuse Prevention (CSAP) awarded the grant, in the amount of $2.25 million for three years, in September 2003. The grant provides substance abuse prevention and early intervention services for the 18-25 year old higher education population. Utah is only one of three states to receive the grant.

The dollar amount that each of the nine campuses received from the grant project was determined by college size. The campuses spent the first year of the grant in a very thorough planning process in preparation for implementation of the grant. The 2004-2005 academic year was the first full year of implementation. The grant provides funds to implement evidence/science-based prevention programs. These are programs that have been shown to be effective through evaluation.

BASICS, Social Norming, and Late Night Activities are some of the programs that the campuses implemented. BASICS is conducted over the course of two interviews. These brief, limited interventions prompt students to change their drinking patterns. The Social Norms approach states that our behavior is influenced by incorrect perceptions of how other members of our social group think and act. Social Norms programs attempt to correct misperceptions by stating factual information (i.e., Most college students DO NOT drink). Late Night Activities offer an alternative to drinking and drugging. They encourage and provide an alcohol and drug-free, fun environment. The campuses will continue to implement programming through the 2005-2006 academic year with a possibility of extending the project into the 2006-2007 academic year.

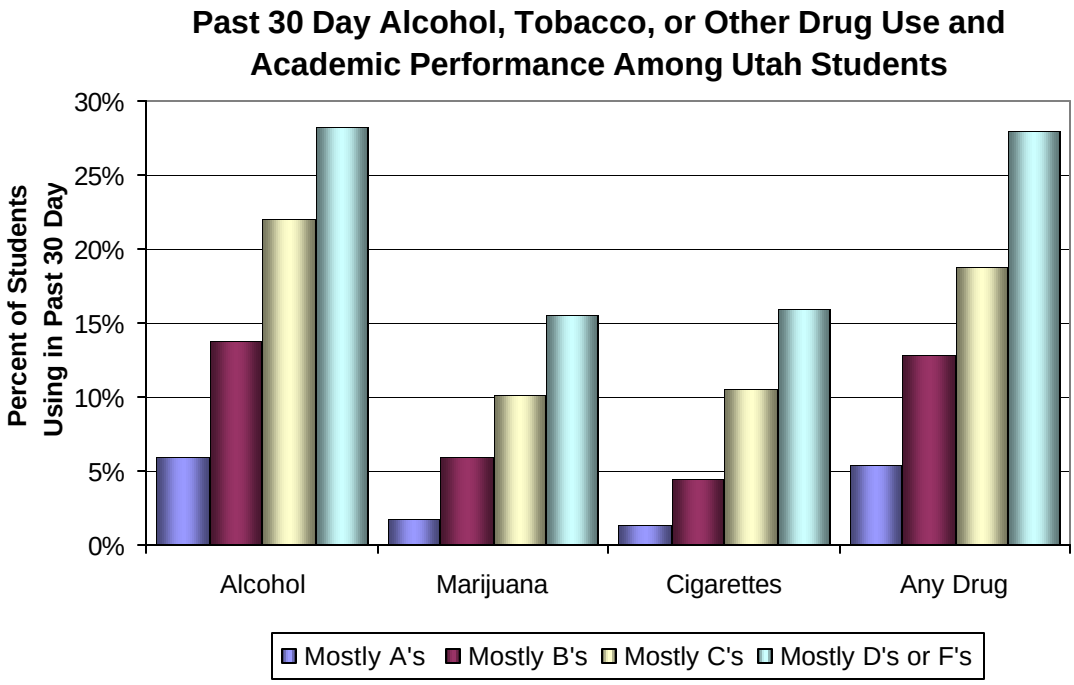
Thorough evaluation, using an independent evaluator, is being conducted with each programming component.

SHARP (Student Health and Risk Prevention) Survey

In collaboration with the Utah State Office of Education and the Utah Department of Health, the Division of Substance Abuse and Mental Health (DSAMH) successfully implemented the "Student Health and Risk Prevention (SHARP) Survey" in school districts throughout Utah in 2003 and 2005. The survey combines three instruments: the Office of Education's Youth Risk Behavior Survey (YRBS), the Department of Health's Youth Tobacco Survey (YTS), and the DSAMH's Prevention Needs Assessment (PNA). Data obtained through the surveys are utilized to identify key risk and protective factors for substance abuse, select science-based prevention programs that will reduce risk and increase protection, and measure progress in reducing substance use/abuse among Utah students in grades 6 through 12.

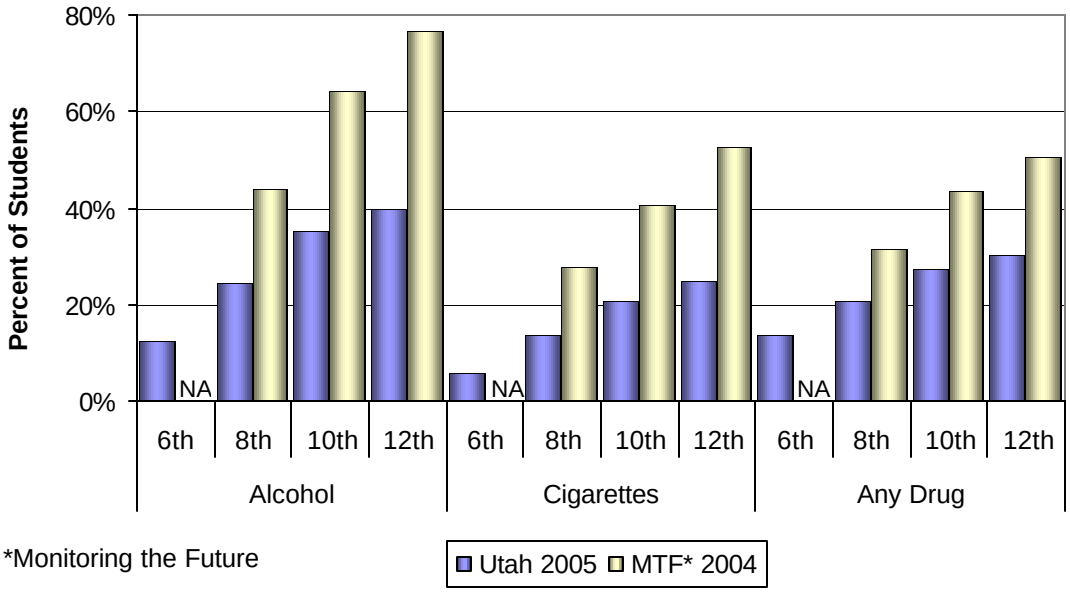
For more information on the SHARP survey see dsamh.utah.gov/sharp.htm.

- Students who don't use alcohol or other substances perform better in school



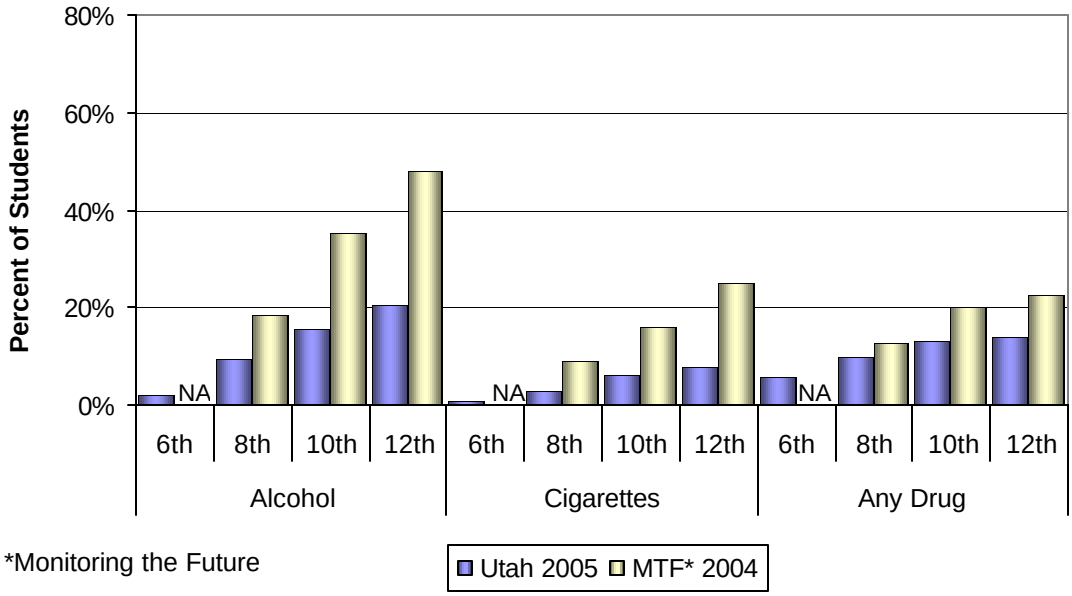
- Utah's students use substances at a rate far less than their national counterparts (Monitoring the Future Study)

Lifetime Substance Use: Utah Use Compared to National Use, Grades 6, 8, 10 and 12



*Monitoring the Future

Past 30 Day Substance Use: Utah Use Compared to National Use, Grades 6, 8, 10 and 12

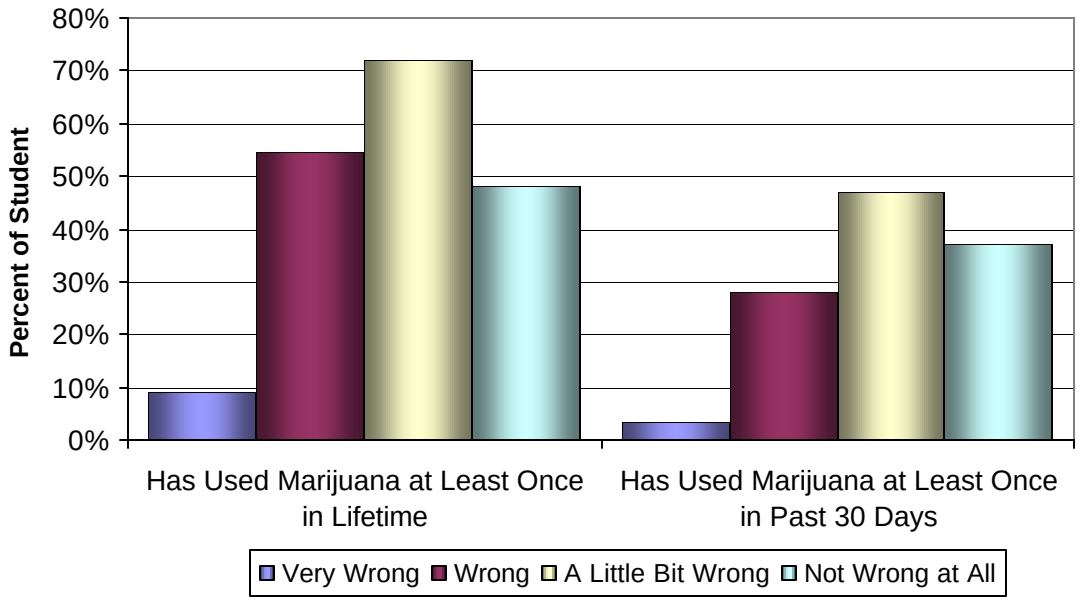


*Monitoring the Future

- Parents have an influence over their student's use of marijuana
  - When the student felt that his or her parent thought it would be "very wrong" for him/her to smoke marijuana, very few of those students used it. However, if the student felt that the parent would only think it was "wrong," use rates increase five-fold.

Marijuana Use in Relation to Perceived Parental Acceptability:

How wrong do your parents feel it would be for you to smoke marijuana?



Higher Education Needs Assessment Survey

During spring of 2005, the Division of Substance Abuse and Mental Health conducted a second statewide survey of college students called the *Utah Higher Education Health Behavior Survey*; the first survey was conducted in spring 2003 with 4,658 participants. The 2005 survey was completed by a total of 11,828 students attending the nine Utah public colleges and Wesminster College. The survey had several objectives, including assessing the prevalence of alcohol, tobacco and other drug use on Utah campuses, measuring the need for substance abuse treatment by college students and measuring the levels of selected risk factors for substance abuse. The survey revealed the following:

- 72% of students under age 21 report it is very easy or sort of easy to get alcohol
- 30% gave someone else money to buy alcohol
- 49% of students report it is very easy or sort of easy to get marijuana
- 23% agree that drugs and alcohol are a normal part of life – 28% are neutral
- 10% need alcohol or drug treatment

In regards to beliefs about peer attitudes and behavior, the survey findings indicate college students have an inflated view of their peers' substance use:

- 40% of students believe that over 21% of their student peers used marijuana in the past year – only 9% actually used
- 55% of students believe that over 41% of their student peers drank alcohol in the past year – only 30% actually drank

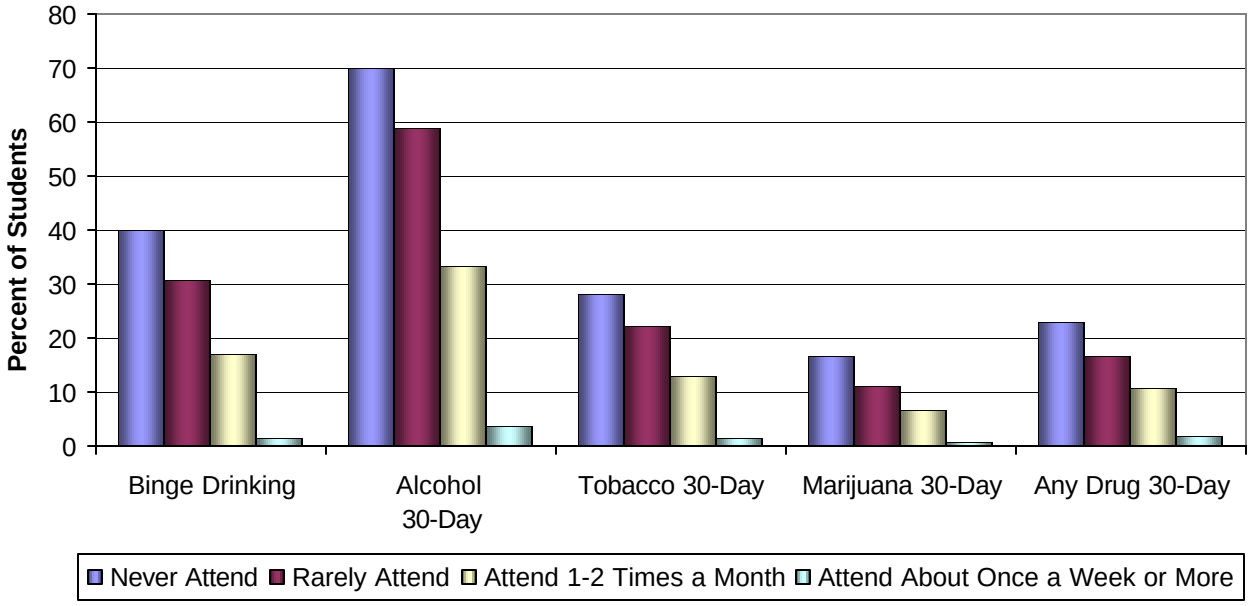
Overall, for most substances, Utah students use at rates that are one-half to one-quarter the national rates.

Past Year Substance Use

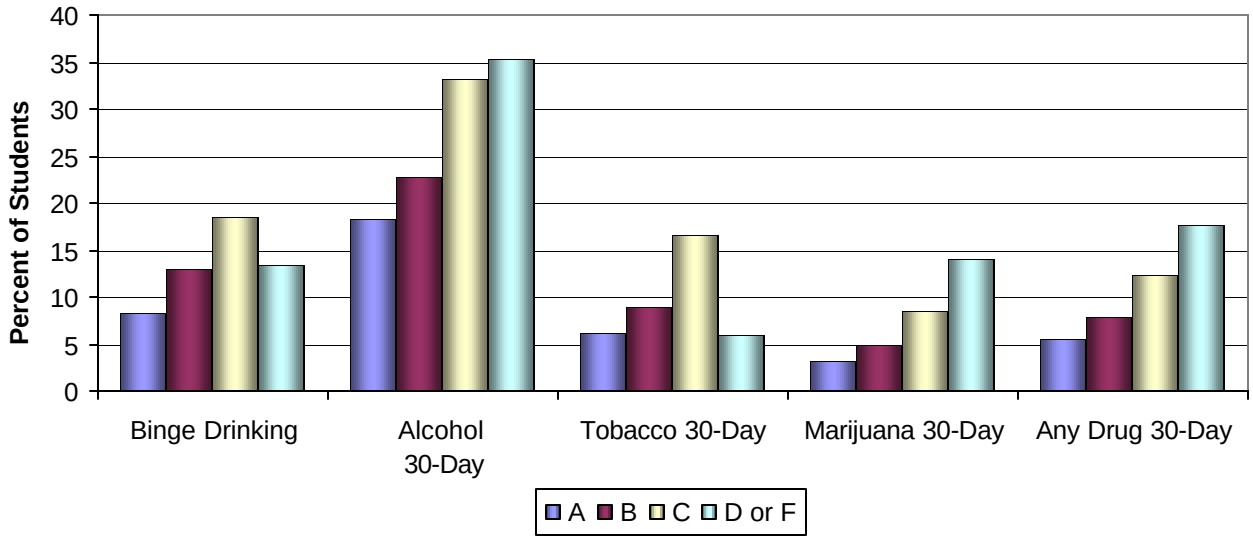
Substance	Utah 2003	Utah 2005	MTF* 2003
Cigarette	---	---	35.2
Alcohol	27.8	30.4	81.7
Marijuana	10.2	9.1	33.7
Hallucinogens	2.1	1.6	7.1
Cocaine	1.8	1.8	5.4
Inhalants	0.5	0.8	1.8
Stimulant	5.2	1.8	7.1
Sedatives	2.5	5.8	6.9**
Opiates	0.5	2.2	8.7
DXM	---	0.8	---
Ecstasy	1.9	1.5	4.4
Other Club Drugs	---	0.4	---
Any Drug	14.5	14.0	36

*Monitoring the Future Study
**MTF value for tranquilizers

Substance Use by Religious Participation



Substance Use by Grade Point Average



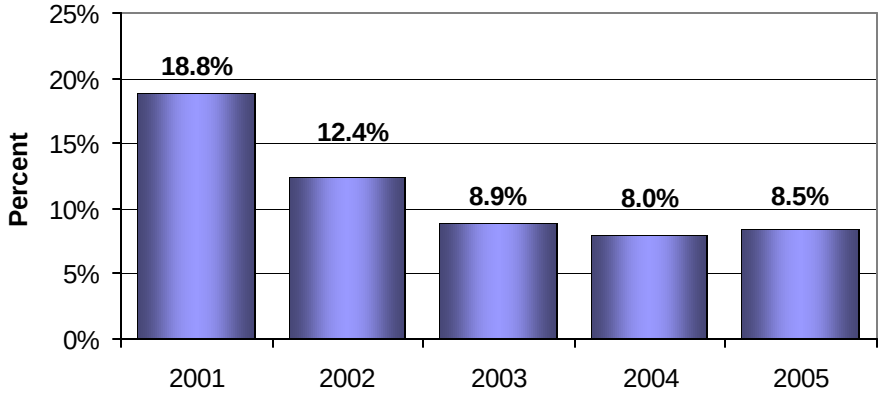
Federal Synar Amendment: Protecting The Nation's Youth from Nicotine Addiction

The Synar Amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the legal age (19 in Utah) and to enforce those laws effectively. States are to achieve a sales-to-minors rate of not greater than 20%. Utah has continued to decrease the number of tobacco sales to minors and has a violation rate of under 10%. This effort is a collaborative effort between the Utah Department of Health and the Division of Substance Abuse and Mental Health.

Summary of Tobacco Inspections Results
FFY2005

	Total Number of Tobacco Outlets	Total Number of Outlets Inspected	Total Number Found in Violation
Bear River	87	83	7
Central	116	112	14
Davis	113	113	4
Salt Lake	609	583	42
Southeast	89	77	3
Southwest	188	184	15
Summit	42	33	0
Tooele	36	36	5
TriCounty	63	52	7
Utah County	193	176	9
Wasatch	26	24	3
Weber/Morgan	146	131	28
Total:	1708	1604	137

Percentage of Outlets Found in Violation
FFY2001 - FFY2005



Drug Overdose Prevention and Education (DOPE)

The Drug Overdose Prevention and Education (DOPE) survey was administered to 304 adults in Salt Lake County during 2002. Survey creation and recruitment of interview participants for the study was coordinated by DSAMH, State Department of Health, Salt Lake County Substance Abuse Services, Salt Lake Valley Health Department, Project Reality, and Harm Reduction Project. Participants were interviewed face-to-face at Harm Reduction Project, Project Reality Methadone Clinic, and Project Reality Residential.

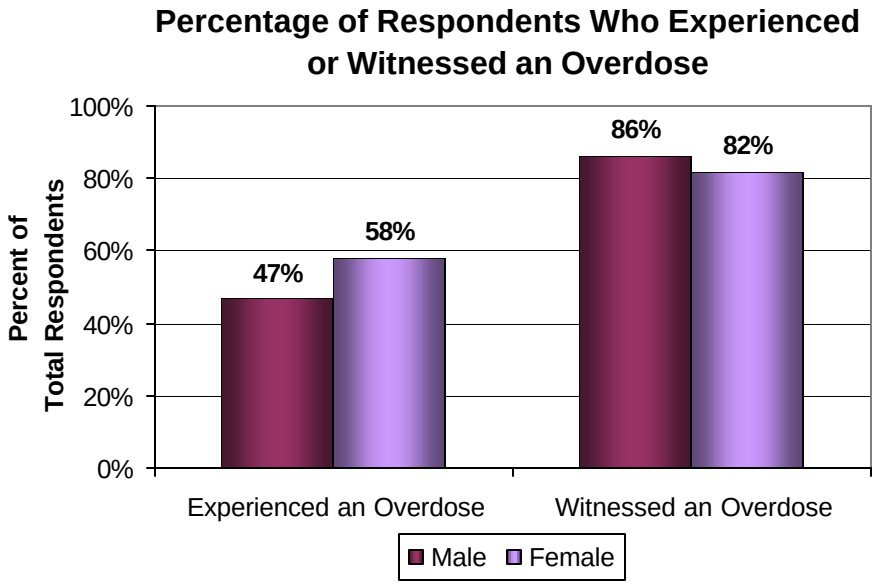
The purpose of the study was to discover answers to many questions about drug overdose. Areas of interest included the reasons for overdose deaths from 1991 to 1999 (there was a seven-fold increase), which drugs are involved with overdoses, how many people know and have used CPR or rescue breathing, the percentage of times the police responded and whether people were arrested or cited at the overdose site. The recruitment of participants from Harm Reduction Project and Project Reality meant that injection drug users, whose drug of choice was usually heroin, completed many of the surveys.

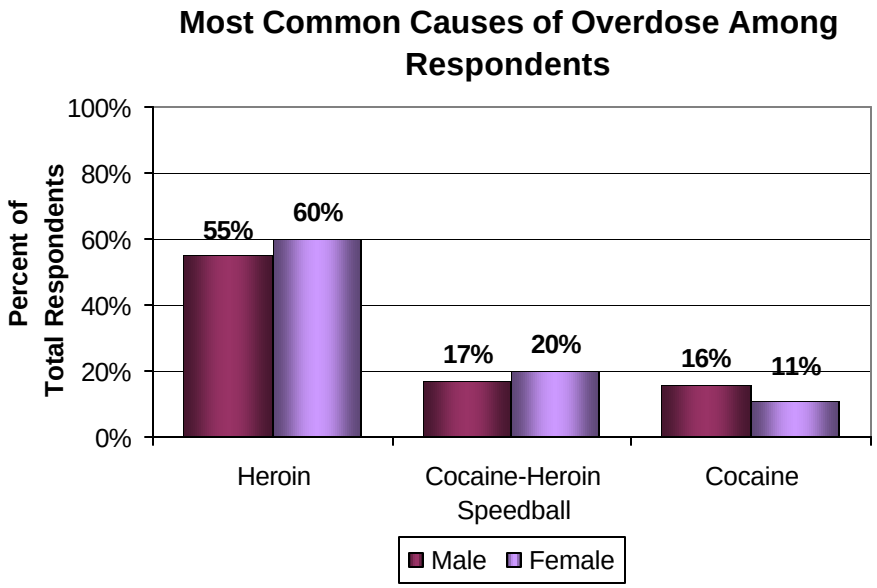
In response to concerns about overdoses, the City of Salt Lake has started a media campaign asking people to call 911 to help prevent overdose deaths. Billboards in Salt Lake County and radio appearances by Salt Lake City Mayor Anderson are bringing the issue of overdoses to the public eye. In addition, a community forum on overdose, hosted by The Harm Reduction Project, will be held in Salt Lake City on January 10, 2006 at the University of Utah.

The following is a general overview of some of the findings (a complete report is being prepared and will be released in Spring 2006):

- Median age of the participant was 42 years with 47.6% male and 52.4% female respondents
- Of those who had experienced an overdose, 68% of females and 78% of males had injected the drug
- Only 31% of the respondents had ever discussed what to do in the event of an overdose with someone
- At the time of the overdose, 52% of respondents were using heroin only, 14% were using cocaine and heroin together, and 21% had used pills
- Females were more likely to have been clean (or drug-free) prior to the overdose than males - 52% versus 35% - the reason for being clean was usually that the victim was in a treatment or detox program
- Emergency services or 911 was called for half of the overdoses and police responded to 76% of those calls - the majority of the time, even when police responded, no one was arrested
- About 16% of witnessed overdoses reported were fatal
- Approximately 10% of all witnessed overdoses were thought to be suicide attempts

The first graph below depicts the total percentage of survey respondents who experienced or witnessed an overdose. The second graph shows the most common drugs reported as causing the overdose. Over half of the oversdoses reported for both males and females were caused by heroin.





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SUBSTANCE ABUSE TREATMENT

System Overview

Treatment for substance abuse and dependence disorders has changed dramatically over the past several years. As the data reflect, the drugs of abuse have changed, as have the patient characteristics. These changes have resulted in more difficult patients with a wide array of issues with which to deal. In response to these changes, the treatment field has developed evidence-based interventions to more effectively address the needs of the patients presenting for treatment.

Screening and Referral

Screening to detect possible substance abuse problems can occur in a variety of settings. Human service agencies, such as Child and Family Services, Aging and Adult Services, Health Clinics, etc., may screen for possible substance abuse or dependence using simple questionnaires or including appropriate questions in their own evaluation process. Individuals involved in the Criminal or Juvenile Justice systems are at exceptional risk for substance abuse disorders and should be screened consistently. As noted in a subsequent section of this document, a significant portion of the substance abuse effort is directed to this population. Referral for treatment comes from many different sources: the client, friends and family, employers, or the justice system. There is no wrong door to treatment!

Assessment

A biopsychosocial evaluation is conducted by the treatment program in order to determine the necessity for treatment. In addition to ascertaining the need for treatment, the assessment is used to determine the diagnosis, generate a treatment plan, access for the appropriate level of care and establish a baseline for determining progress. In addition to a clinical interview, the Division of Substance Abuse and Mental Health (DSAMH) requires that individuals complete the Addiction Severity Index (ASI) for adults. All evaluation tools are science-based and crosswalk directly to the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) for levels of care and diagnostic criteria.

Placement into Treatment

The client is placed into the appropriate level of care as determined by the ASAM PPC. In addition to diagnosis, factors affecting the proper placement may include availability of a particular level of care, waiting lists, or client preference.

Levels of Care and/or Service Types

DSAMH requires that the ASAM PPC be used to determine the most appropriate setting for treatment. The Criteria are science-based and provide a structure to place the client in the least restrictive, most effective level of treatment possible. ASAM has described several levels of care to treat individuals with a substance abuse/dependence diagnosis. Although all of these levels of care are not available in all areas of Utah, all providers are required to provide at least outpatient counseling and have the ability to obtain residential services. Clients move between levels of care based on their progress or lack of progress in treatment.

- Outpatient Treatment: Outpatient treatment is provided in an organized setting by licensed treatment personnel. These services are provided in scheduled individual, family, or group sessions, usually fewer than nine hours per week. The goal of outpatient treatment is to help the individual change alcohol and or drug use behaviors by addressing their attitudinal, behavioral and lifestyle issues.

- Intensive Outpatient Treatment: Intensive outpatient treatment services may take place in outpatient or partial hospitalization settings. These programs provide education, treatment assistance and help patients in developing coping skills to live in the "real world." Services include group therapy, individual therapy, case management, crisis services and skill development and generally are between nine and 20 hours per week. They also arrange for medical, psychiatric and psychopharmacological consultation as needed.

- Residential/Inpatient Treatment: This level of care is delivered in a 24-hour, live-in setting. The program is staffed 24 hours a day by licensed treatment staff and may include other professionals such as mental health staff and medical staff. The safe, stable, planned environment helps patients develop recovery skills and succeed in treatment. Individual and group therapy are provided as well as skill development, parenting classes, anger management and other evidence-based treatment. This level of care includes short-term and long-term treatment settings.

- Detoxification: The main objective of detoxification is to stop the momentum of substance use and engage the client in treatment. This includes addressing the withdrawal syndromes affecting the patient physically and psychologically. The goals of care are 1) avoidance of the potentially hazardous consequences of discontinuation of alcohol and other drugs of dependence; 2) facilitation of the patient's completion of detoxification and linkages and timely entry into continued medical, addiction or mental health treatment or self-help recovery as indicated; and 3) promotion of dignity and easing of discomfort during the withdrawal process.

- Opioid Maintenance Therapy (OMT): "Opioid Maintenance Therapy" is an umbrella term that encompasses a variety of treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, which occupy opiate receptors in the brain, extinguish drug craving and establish a maintenance state. The result is a continuously maintained state of drug tolerance in which the therapeutic agent does not produce euphoria, intoxication, or withdrawal symptoms.

Treatment

Addiction is a complex interaction of biological, social and toxic factors, heredity, and environment. Given these multiple influences, there is no one treatment that is appropriate for everyone. Treatment should be science-based and individualized to meet the needs of those entering treatment; be they adolescent marijuana users, addicted pregnant women or chronic alcoholics. Certain groups of clients require extraordinary treatment and may require longer lengths of care. These populations include:

- Pregnant and parenting women, especially those addicted to methamphetamine.
- Individuals with co-occurring mental illness disorder.
- Criminal justice referrals.

A variety of interventions, including pharmacological adjuncts, have been validated over the past few years. Self-help and 12-step groups continue to be an important support for those in treatment but should not be considered a stand alone treatment.

Transfer during treatment

DSAMH encourages moving clients from one treatment level to another based on successful completion of treatment objectives or lack of progress at a particular level. Transfer between programs or Local Authority districts may be necessary based on the needs of a particular patient and the resources available.

Discharge

At completion of treatment, the patient is discharged from service. A discharge plan is created and should include aftercare and self-help meetings. Many patients leave programs without completing treatment. This should not adversely affect their return to treatment at a later time.

The following table illustrates the continuum of substance abuse prevention and treatment services provided in Utah.

Utah Division of Substance Abuse and Mental Health
Health Substance Abuse Services Continuum

Function	Prevention/Intervention			Treatment		
Program Level	***Universal***	***Selected***	***Indicated***	***Outpatient***	***Intensive Outpatient***	***Residential***
Appropriate For:	• General Population	• At risk	• Using, but does not meet DSM IV Diagnostic Criteria	• DSM IV Diagnosis of Abuse or Dependence	• Serious Abuse or Dependence	• Serious Abuse or Dependence
Indentification Process	• General Interests	• Referral	• SAS Screening	• ASI (adult) or CASI (adolescent)	• ASI (adult) or CASI (adolescent)	• ASI (adult) or CASI (adolescent)
Populations	• K-12 Students • General Population	• School Drop-outs, Children of Alchoholics, etc.	• DUI Convictions, Drug Possession Charges, etc.	• Appropriate for general population, Criminal Justice referrals including DUI when problem identified, Women and Children, Adolescents, Poly-drug users, Meth addicted, Alcoholics, etc.		
Program Methods	• Risk/ Protective Factor Model •Prevention Dimensions	• Risk/ Protective Factor Model	• Risk/ Protective Factor Model • Education Intervention Programs	• Evidence Based, Preferred Practices, ASAM Patient Placement Criteria		

Utahns in Need of Substance Abuse Treatment

The results of the 2000 State Treatment Needs Assessment Survey and the 2005 State Prevention Needs Assessment Survey indicated:

- 4.9% of adults in Utah were classified as dependent on either alcohol or drugs and in need of treatment services - the 1996 survey reported that 6.1% of adults were classified as dependent, indicating a decrease by more than 1%
- 6.4% of Utah youth age 12 to 17 are dependent on drugs or alcohol
- The public substance abuse treatment system, at capacity, is currently serving approximately 17,760 individuals, or 22.5% of the actual need in the state
- A combined total of approximately 103,186 adults and youth are in need of substance abuse treatment services

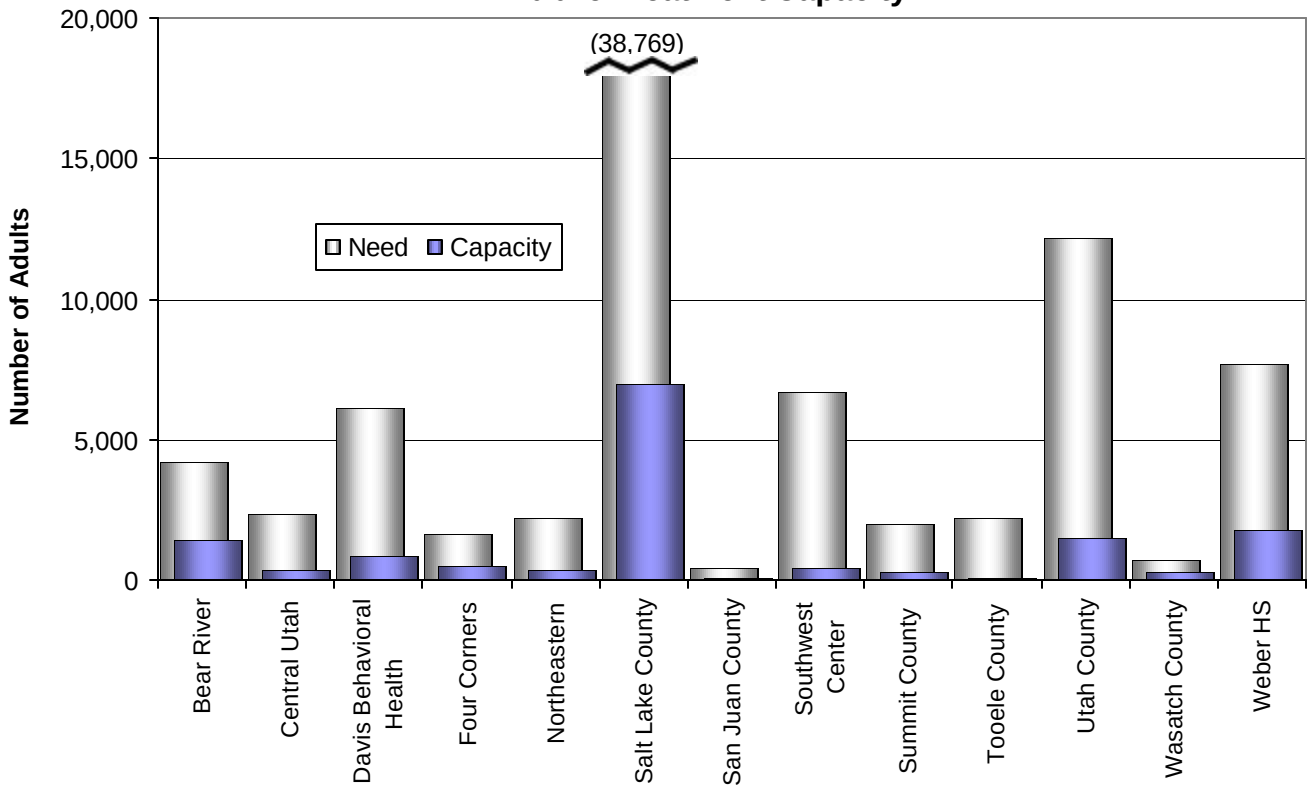
The percentage of adults and youth needing treatment by service district varies considerably. The following table demonstates the actual number of adults and youth who need treatment, by district. The current capacity of each district, or the number of indiviuals who were actually served in FY2005, is also included to illustrate the unmet need. The same data is depicted on graphs on the opposite page.

Need For Treatment Survey Results

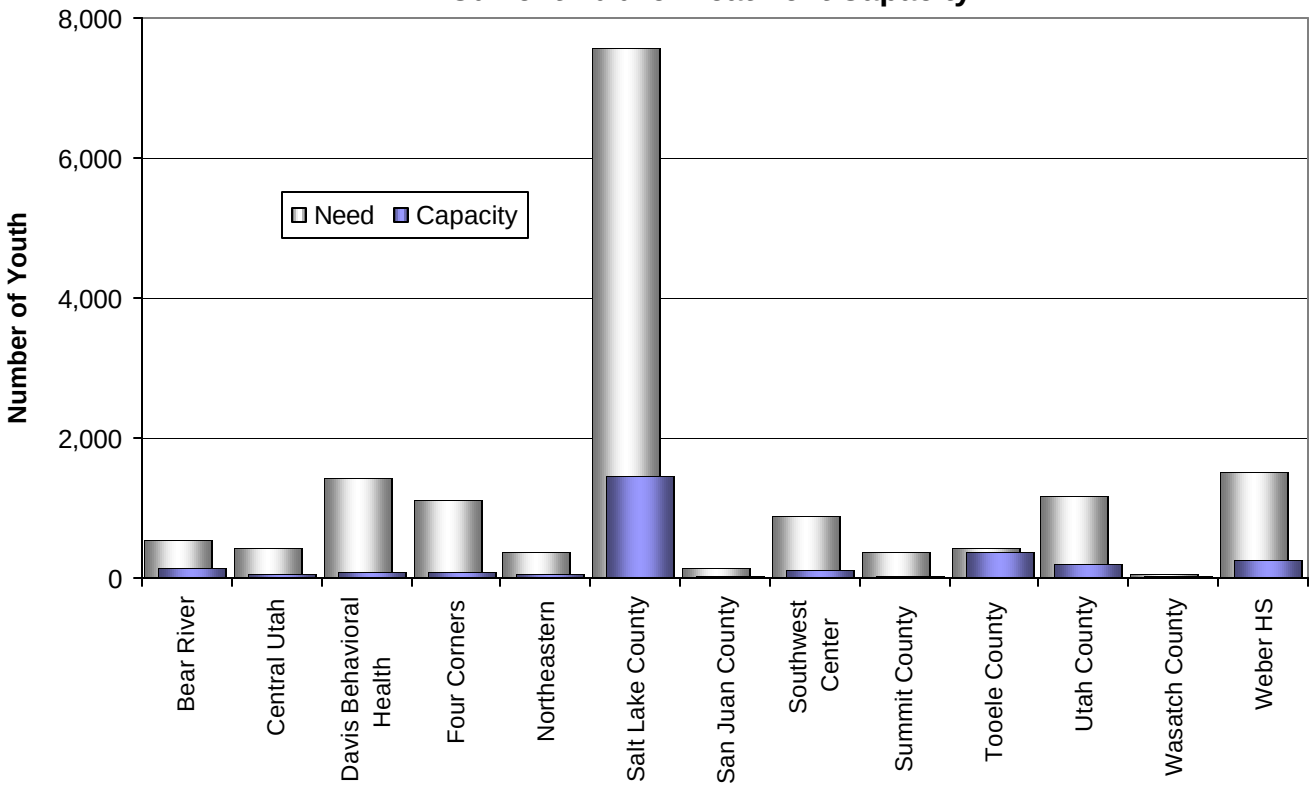
District	Adults (18 years +)			Youth (12-17)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
Bear River	4.1%	4,170	1,407	3.8%	534	156
Central Utah	5.9%	2,384	357	5.5%	415	58
Davis County	3.3%	6,144	871	5.0%	1,420	88
Four Corners	5.7%	1,602	501	10.8%	1,111	76
Northeastern	7.7%	2,231	333	8.2%	375	46
Salt Lake County	5.7%	38,769	6,955	8.7%	7,574	1,448
San Juan County	4.2%	399	74	8.3%	157	29
Southwest Center	5.1%	6,657	458	5.4%	873	119
Summit County	7.5%	1,991	290	10.5%	359	33
Tooele County	6.4%	2,201	65	8.6%	433	369
Utah County	4.1%	12,187	1,509	2.8%	1,180	206
Wasatch County	5.4%	741	254	2.7%	55	25
Weber Human Services	5.0%	7,709	1,779	7.4%	1,517	254
Total:	4.9%*	87,184	14,853	6.4%**	16,002	2,907

* Taken from the 2000 State of Utah Telephone Household Survey Treatment Needs Assessment Project
** Taken from the 2005 State of Utah Prevention Needs Assessment Survey

Number of Adults who Need Treatment Compared to the Current Public Treatment Capacity



Number of Youth (Age 12-17) who Need Treatment Compared to the Current Public Treatment Capacity



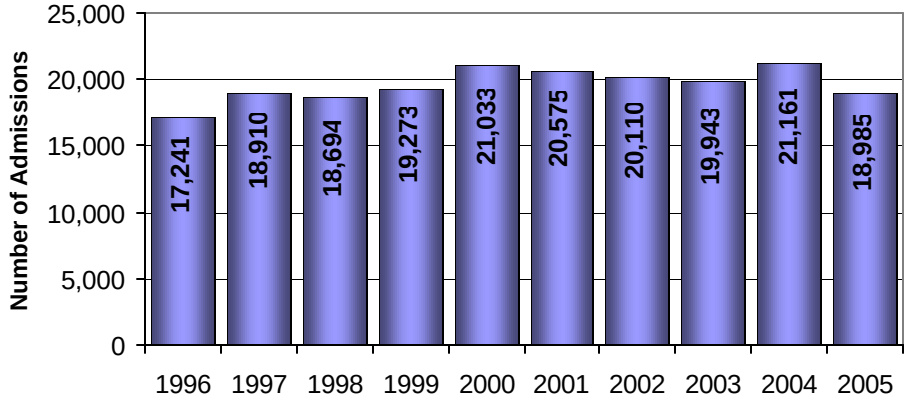
Number of Treatment Admissions

The Federal Government requires that each state collect demographic and treatment data on all patients admitted into any publicly-funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the source that the Division of Substance Abuse and Mental Health uses for treatment admission numbers and characteristics of patients entering treatment.

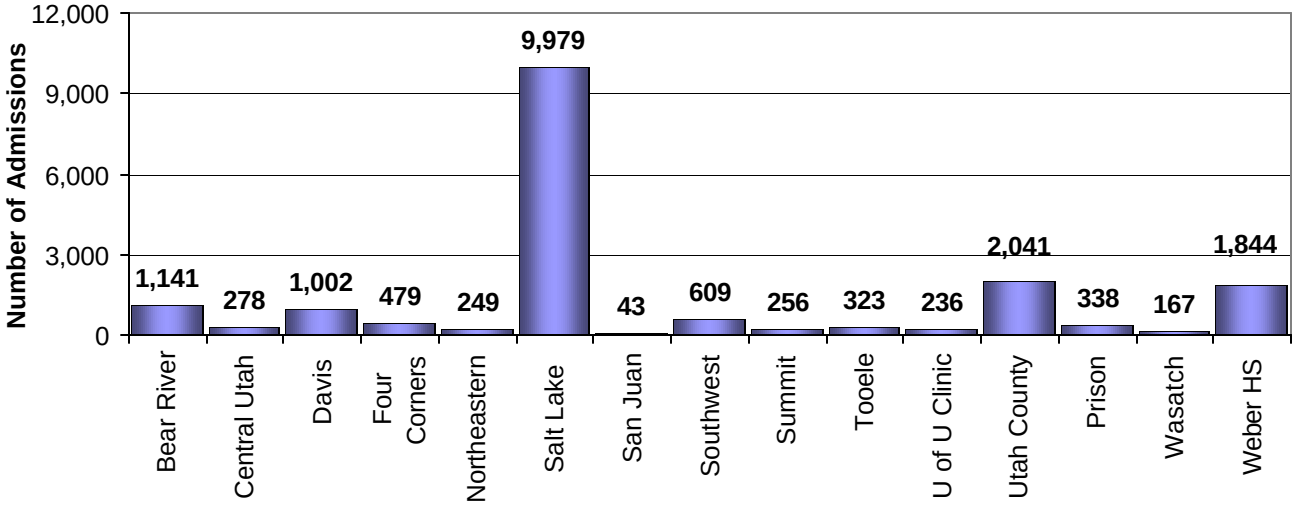
The Division collects this data from the Local Substance Abuse Authorities (LSAAs) on a quarterly basis. TEDS has been collected each year since 1991. This allows the Division to report trend data based on treatment admissions over the past ten years (see first chart below).

The second chart below shows the number of admissions to each Local Authority, the University of Utah Clinic, and the Utah State Prison area in fiscal year 2005. Over half of all treatment admissions were served by Salt Lake County.

Substance Abuse Treatment Admissions in Utah
FY1996 to FY2005



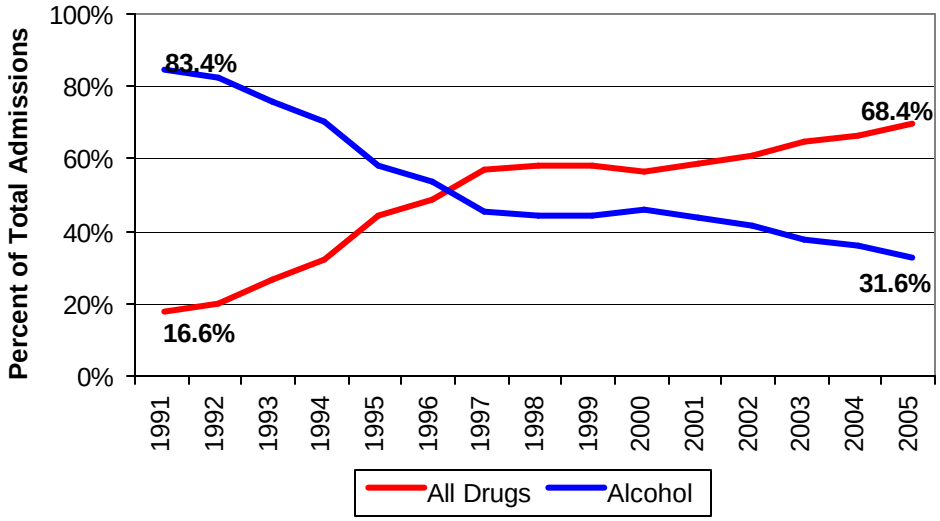
Substance Abuse Treatment Admissions in Utah by Local Authority Area
Fiscal Year 2005



Primary Substance of Abuse

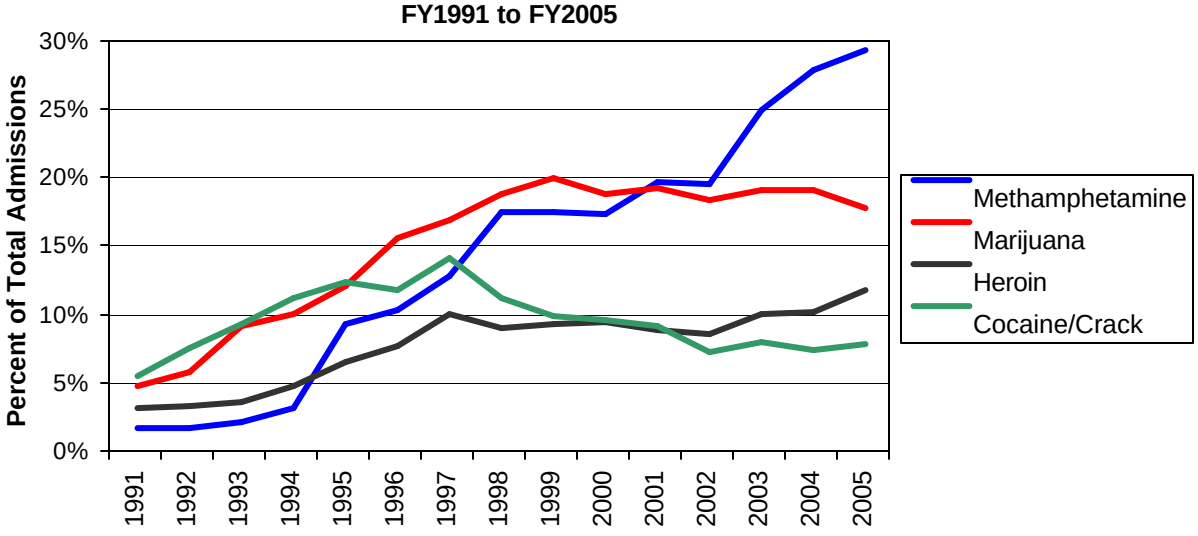
In 1991, 83% of Utah patients came into treatment for help with alcohol dependence; in fiscal year 2005 that percentage fell to 32%. On the other hand, the percentage of patients entering treatment for illicit drug abuse/ dependence has risen from 17% in 1991 to 68% in 2005.

Patient Admissions for Alcohol vs. Drug Dependence
FY1991 to FY2005



Over 60% of the patients use one of four different drugs: marijuana, methamphetamine, cocaine/ crack, and heroin. The chart below shows the trends of the use of these four drugs over the past 15 years. In 1991, cocaine was the most common illicit drug used, methamphetamine is now the most common illict drug used among patients, surpassing marijuana in fiscal year 2001. The gap between methamphetamine and marijuana has since widened significanlty. Marijuana continues to be one of the most common drugs used in Utah, and is often used in combination with other illicit drugs and alcohol.

Top Four Illicit Drugs of Choice by Year (Excluding Alcohol)
FY1991 to FY2005



The table below lists the primary substances used by patients, as reported at admission to treatment. The percentages represent patients, by gender, who reported the substance as their primary substance of abuse. As this table illustrates, the primary drug of choice differs among the male and female treatment populations. The illicit drug of choice among men is methamphetamine (21%), closely followed by marijuana (18%). Admissions for use of methamphetamines account for over 38% of the female admissions. While alcohol continues to be the primary substance of abuse for men, methamphetamine continues to be the primary substance of abuse for women admitted to treatment.

Primary Substance by Gender
FY2005

	Male	Female	Total
Alcohol	36.8%	22.2%	31.2%
Marijuana/Hashish	18.4%	12.5%	16.1%
Heroin	11.5%	8.6%	10.4%
Other Opiates/Synthetics	3.4%	6.4%	4.5%
Club Drugs	0.1%	0.1%	0.1%
Other Hallucinogens	0.2%	0.2%	0.2%
Cocaine/Crack	6.0%	7.2%	6.4%
Methamphetamine	21.0%	38.3%	27.6%
Other Stimulants	0.3%	0.6%	0.4%
Benzodiazepines	0.3%	1.2%	0.6%
Other Sedative-Hypnotics	0.0%	0.4%	0.2%
Inhalants	0.1%	0.1%	0.1%
Over-the-Counter	0.1%	0.0%	0.1%
Other	0.1%	0.1%	0.1%
None/Missing	1.8%	2.3%	2.0%
Total:	11,742	7,243	18,985

The table below contains the raw numbers for the primary substance of abuse by age grouping. It shows that alcohol is the most common substance of abuse for all but two groups. Most adolescent (under 18) admissions use marijuana and methamphetamine continues to be the drug of choice for the 26 to 35 cohort.

Primary Substance of Abuse by Age Grouping
FY2005

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	472	1,213	1,326	1,568	1,298	38	10	5,925
Marijuana/Hashish	1,343	904	495	229	89	0	4	3,064
Heroin	18	558	556	470	364	2	0	1,968
Other Opiates/Synthetics	18	250	295	183	108	1	0	855
Club Drugs	6	13	5	1	1	0	0	26
Other Hallucinogens	7	17	12	5	2	0	0	43
Cocaine/Crack	44	231	339	436	172	0	1	1,223
Methamphetamine	187	1,624	1,998	1,126	291	0	9	5,235
Other Stimulants	1	18	24	19	14	0	0	76
Benzodiazepines	2	27	29	40	18	0	0	116
Other Sedative-Hypnotics	1	3	11	9	6	0	0	30
Inhalants	11	5	3	0	0	0	0	19
Over-the-Counter	3	7	1	0	1	0	0	12
Other	2	5	5	4	3	0	0	19
None/Missing	240	26	23	18	9	0	58	374
Total:	2,355	4,901	5,122	4,108	2,376	41	82	18,985

Primary Substance of Abuse by Local Authority

Bear River Health Department

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Bear River Health Department

	Male	Female	Total
Alcohol	58.7%	51.2%	56.5%
Marijuana/Hashish	21.9%	8.4%	18.0%
Heroin	0.5%	0.0%	0.4%
Other Opiates/Synthetics	3.0%	8.1%	4.5%
Cocaine/Crack	1.1%	1.5%	1.2%
Methamphetamine	14.5%	28.6%	18.6%
Other Stimulants	0.0%	0.3%	0.1%
Benzodiazepines	0.0%	0.3%	0.1%
Other Sedative-Hypnotics	0.1%	1.5%	0.5%
Inhalants	0.2%	0.0%	0.2%
Total:	809	332	1,141

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Bear River Health Department

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	43	351	126	78	42	4	1	645
Marijuana/Hashish	49	89	41	17	9	0	0	205
Heroin	0	0	4	0	0	0	0	4
Other Opiates/Synthetics	5	8	17	14	6	1	0	51
Cocaine/Crack	0	2	4	8	0	0	0	14
Methamphetamine	7	67	78	48	12	0	0	212
Other Stimulants	0	0	0	0	1	0	0	1
Benzodiazepines	0	0	0	1	0	0	0	1
Other Sedative-Hypnotics	1	1	3	0	1	0	0	6
Inhalants	2	0	0	0	0	0	0	2
Total:	107	518	273	166	71	5	1	1,141

Central Utah Counseling Center

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Central Utah Counseling Center

	Male	Female	Total
Alcohol	43.0%	38.7%	41.4%
Marijuana/Hashish	25.0%	15.1%	21.2%
Heroin	2.3%	2.8%	2.5%
Other Opiates/Synthetics	3.5%	10.4%	6.1%
Cocaine/Crack	2.3%	1.9%	2.2%
Methamphetamine	22.1%	28.3%	24.5%
Other Stimulants	0.6%	0.9%	0.7%
Benzodiazepines	0.0%	0.9%	0.4%
Inhalants	0.6%	0.0%	0.4%
None/Missing	0.6%	0.9%	0.7%
Total:	172	106	278

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Central Utah Counseling Center

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	18	32	23	21	19	1	1	115
Marijuana/Hashish	18	20	11	7	3	0	0	59
Heroin	0	3	3	1	0	0	0	7
Other Opiates/Synthetics	0	3	6	6	2	0	0	17
Cocaine/Crack	0	3	1	1	1	0	0	6
Methamphetamine	1	19	26	13	9	0	0	68
Other Stimulants	0	0	0	1	1	0	0	2
Benzodiazepines	0	0	0	1	0	0	0	1
Inhalants	0	1	0	0	0	0	0	1
None/Missing	2	0	0	0	0	0	0	2
Total:	39	81	70	51	35	1	1	278

Davis Behavioral Health

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Davis Behavioral Health

	Male	Female	Total
Alcohol	27.6%	18.5%	23.7%
Marijuana/Hashish	23.6%	12.2%	18.7%
Heroin	4.0%	3.2%	3.7%
Other Opiates/Synthetics	3.2%	6.2%	4.5%
Other Hallucinogens	0.7%	0.2%	0.5%
Cocaine/Crack	4.2%	4.6%	4.4%
Methamphetamine	34.6%	52.4%	42.3%
Other Stimulants	0.2%	0.9%	0.5%
Benzodiazepines	0.0%	0.5%	0.2%
Other	0.2%	0.0%	0.1%
None/Missing	1.8%	1.2%	1.5%
Total:	569	433	1,002

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Davis Behavioral Health

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	10	27	77	72	48	1	2	237
Marijuana/Hashish	49	80	33	18	7	0	0	187
Heroin	0	18	12	7	0	0	0	37
Other Opiates/Synthetics	0	8	23	9	5	0	0	45
Other Hallucinogens	1	2	2	0	0	0	0	5
Cocaine/Crack	0	17	15	3	9	0	0	44
Methamphetamine	7	154	142	100	19	0	2	424
Other Stimulants	0	1	0	1	3	0	0	5
Benzodiazepines	0	2	0	0	0	0	0	2
Other	0	0	1	0	0	0	0	1
None/Missing	1	11	0	3	0	0	0	15
Total:	68	320	305	213	91	1	4	1,002

Four Corners Community Behavioral Health

Primary Substance by Gender

Fiscal Year 2005 Substance Abuse Admissions
Four Corners Community Behavioral Health

	Male	Female	Total
Alcohol	60.0%	35.5%	49.1%
Marijuana/Hashish	22.3%	21.5%	21.9%
Heroin	1.1%	0.5%	0.8%
Other Opiates/Synthetics	1.9%	8.4%	4.8%
Cocaine/Crack	1.1%	0.5%	0.8%
Methamphetamine	13.6%	31.8%	21.7%
Other Stimulants	0.0%	0.5%	0.2%
Benzodiazepines	0.0%	1.4%	0.6%
Total:	265	214	479

Primary Substance of Abuse by Age Grouping

Fiscal Year 2005 Substance Abuse Admissions
Four Corners Community Behavioral Health

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Total
Alcohol	20	61	62	53	36	3	235
Marijuana/Hashish	24	46	19	14	2	0	105
Heroin	0	2	0	2	0	0	4
Other Opiates/Synthetics	0	10	7	3	3	0	23
Cocaine/Crack	0	0	2	2	0	0	4
Methamphetamine	1	19	48	29	7	0	104
Other Stimulants	0	0	1	0	0	0	1
Benzodiazepines	0	0	0	3	0	0	3
Total:	45	138	139	106	48	3	479

Heber Valley Counseling

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Heber Valley Counseling

	Male	Female	Total
Alcohol	69.4%	48.8%	64.1%
Marijuana/Hashish	8.9%	16.3%	10.8%
Heroin	0.8%	0.0%	0.6%
Other Opiates/Synthetics	7.3%	7.0%	7.2%
Cocaine/Crack	1.6%	7.0%	3.0%
Methamphetamine	12.1%	11.6%	12.0%
Benzodiazepines	0.0%	2.3%	0.6%
None/Missing	0.0%	7.0%	1.8%
Total:	124	43	167

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Heber Valley Counseling

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	Missing	Total
Alcohol	6	32	18	29	21	1	107
Marijuana/Hashish	3	13	2	0	0	0	18
Heroin	0	0	1	0	0	0	1
Other Opiates/Synthetics	0	3	6	1	2	0	12
Cocaine/Crack	0	2	0	1	2	0	5
Methamphetamine	0	9	3	5	3	0	20
Benzodiazepines	0	0	0	0	1	0	1
None/Missing	1	0	1	1	0	0	3
Total:	10	59	31	37	29	1	167

Northeastern Counseling Center

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Northeastern Counseling Center

	Male	Female	Total
Alcohol	42.4%	35.7%	39.8%
Marijuana/Hashish	23.2%	9.2%	17.7%
Other Opiates/Synthetics	1.3%	5.1%	2.8%
Other Hallucinogens	0.7%	1.0%	0.8%
Cocaine/Crack	1.3%	0.0%	0.8%
Methamphetamine	23.8%	35.7%	28.5%
Other Stimulants	6.6%	13.3%	9.2%
None/Missing	0.7%	0.0%	0.4%
Total:	151	98	249

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Northeastern Counseling Center

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	10	20	23	29	14	1	2	99
Marijuana/Hashish	7	12	12	6	3	0	4	44
Other Opiates/Synthetics	1	0	4	2	0	0	0	7
Other Hallucinogens	1	0	1	0	0	0	0	2
Cocaine/Crack	0	1	0	1	0	0	0	2
Methamphetamine	1	18	30	18	2	0	2	71
Other Stimulants	0	5	11	4	3	0	0	23
None/Missing	0	1	0	0	0	0	0	1
Total:	20	57	81	60	22	1	8	249

Salt Lake County Division of Substance Abuse

Primary Substance by Gender

Fiscal Year 2005 Substance Abuse Admissions
Salt Lake County Division of Substance Abuse

	Male	Female	Total
Alcohol	35.6%	19.1%	29.2%
Marijuana/Hashish	15.4%	10.2%	13.4%
Heroin	16.5%	12.7%	15.0%
Other Opiates/Synthetics	2.6%	5.6%	3.8%
Club Drugs	0.1%	0.1%	0.1%
Other Hallucinogens	0.3%	0.3%	0.3%
Cocaine/Crack	8.1%	9.7%	8.7%
Methamphetamine	17.3%	37.0%	25.0%
Other Stimulants	0.3%	0.2%	0.3%
Benzodiazepines	0.3%	0.6%	0.4%
Other Sedative-Hypnotics	0.0%	0.1%	0.1%
Inhalants	0.2%	0.1%	0.1%
Over-the-Counter	0.1%	0.1%	0.1%
Other	0.0%	0.1%	0.0%
None/Missing	3.2%	4.1%	3.5%
Total:	6,119	3,860	9,979

Primary Substance of Abuse by Age Grouping

Fiscal Year 2005 Substance Abuse Admissions
Salt Lake County Division of Substance Abuse

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	193	299	592	932	880	18	0	2,914
Marijuana/Hashish	843	229	162	66	34	0	0	1,334
Heroin	5	291	447	405	351	2	0	1,501
Other Opiates/Synthetics	6	86	118	99	65	1	0	375
Club Drugs	3	3	1	0	1	0	0	8
Other Hallucinogens	5	12	9	5	2	0	0	33
Cocaine/Crack	33	145	231	333	130	0	1	873
Methamphetamine	107	752	924	548	156	0	3	2,490
Other Stimulants	0	2	6	12	5	0	0	25
Benzodiazepines	0	8	12	14	8	0	0	42
Other Sedative-Hypnotics	0	0	2	2	3	0	0	7
Inhalants	7	4	3	0	0	0	0	14
Over-the-Counter	3	4	0	0	0	0	0	7
Other	0	2	0	1	1	0	0	4
None/Missing	236	13	22	14	9	0	58	352
Total:	1,441	1,850	2,529	2,431	1,645	21	62	9,979

San Juan Counseling

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
San Juan Counseling

	Male	Female	Total
Alcohol	70.0%	76.9%	72.1%
Marijuana/Hashish	26.7%	0.0%	18.6%
Other Opiates/Synthetics	0.0%	7.7%	2.3%
Cocaine/Crack	0.0%	7.7%	2.3%
Methamphetamine	3.3%	7.7%	4.7%
Total:	30	13	43

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
San Juan Counseling

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Total
Alcohol	6	4	8	7	5	1	31
Marijuana/Hashish	5	1	1	1	0	0	8
Other Opiates/Synthetics	0	0	0	0	1	0	1
Cocaine/Crack	0	0	1	0	0	0	1
Methamphetamine	0	1	0	1	0	0	2
Total:	11	6	10	9	6	1	43

Southwest Behavioral Health Center

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Southwest Behavioral Health Center

	Male	Female	Total
Alcohol	27.2%	21.4%	24.6%
Marijuana/Hashish	22.2%	11.8%	17.6%
Heroin	1.8%	0.7%	1.3%
Other Opiates/Synthetics	5.9%	6.6%	6.2%
Cocaine/Crack	2.4%	2.6%	2.5%
Methamphetamine	39.3%	53.9%	45.8%
Other Stimulants	0.0%	0.7%	0.3%
Benzodiazepines	1.2%	1.5%	1.3%
Other Sedative-Hypnotics	0.0%	0.7%	0.3%
Total:	338	271	609

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Southwest Behavioral Health Center

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Missing	Total
Alcohol	14	30	45	34	25	1	1	150
Marijuana/Hashish	48	36	13	6	4	0	0	107
Heroin	1	2	4	0	1	0	0	8
Other Opiates/Synthetics	4	10	19	5	0	0	0	38
Cocaine/Crack	6	2	1	3	3	0	0	15
Methamphetamine	14	84	118	47	16	0	0	279
Other Stimulants	0	2	0	0	0	0	0	2
Benzodiazepines	2	1	0	3	2	0	0	8
Other Sedative-Hypnotics	0	0	0	2	0	0	0	2
Total:	89	167	200	100	51	1	1	609

Summit County - VMH

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Summit County - VMH

	Male	Female	Total
Alcohol	83.6%	87.3%	84.4%
Marijuana/Hashish	10.0%	3.6%	8.6%
Heroin	1.0%	0.0%	0.8%
Other Opiates/Synthetics	1.0%	1.8%	1.2%
Club Drugs	0.5%	0.0%	0.4%
Cocaine/Crack	2.5%	1.8%	2.3%
Methamphetamine	1.0%	5.5%	2.0%
Other	0.5%	0.0%	0.4%
Total:	201	55	256

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Summit County - VMH

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Total
Alcohol	19	77	51	38	28	3	216
Marijuana/Hashish	4	8	8	1	1	0	22
Heroin	1	0	0	1	0	0	2
Other Opiates/Synthetics	0	2	0	1	0	0	3
Club Drugs	0	0	1	0	0	0	1
Cocaine/Crack	0	1	2	1	2	0	6
Methamphetamine	0	2	1	1	1	0	5
Other	0	0	1	0	0	0	1
Total:	24	90	64	43	32	3	256

Tooele County - VMH

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Tooele County - VMH

	Male	Female	Total
Alcohol	53.9%	41.9%	50.5%
Marijuana/Hashish	20.4%	17.2%	19.5%
Heroin	1.3%	1.1%	1.2%
Other Opiates/Synthetics	1.7%	7.5%	3.4%
Club Drugs	0.9%	0.0%	0.6%
Cocaine/Crack	3.5%	1.1%	2.8%
Methamphetamine	18.3%	28.0%	21.1%
Benzodiazepines	0.0%	1.1%	0.3%
Other Sedative-Hypnotics	0.0%	1.1%	0.3%
Other	0.0%	1.1%	0.3%
Total:	230	93	323

Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Tooele County - VMH

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	Total
Alcohol	20	52	38	28	25	163
Marijuana/Hashish	26	24	7	4	2	63
Heroin	0	2	1	1	0	4
Other Opiates/Synthetics	1	1	5	4	0	11
Club Drugs	0	0	2	0	0	2
Cocaine/Crack	0	1	3	4	1	9
Methamphetamine	2	26	29	10	1	68
Benzodiazepines	0	0	1	0	0	1
Other Sedative-Hypnotics	0	1	0	0	0	1
Other	0	0	0	1	0	1
Total:	49	107	86	52	29	323

Utah County Division of Substance Abuse

Primary Substance by Gender

Fiscal Year 2005 Substance Abuse Admissions
Utah County Division of Substance Abuse

	Male	Female	Total
Alcohol	25.3%	13.6%	20.7%
Marijuana/Hashish	21.8%	18.4%	20.4%
Heroin	20.3%	9.9%	16.2%
Other Opiates/Synthetics	9.5%	11.2%	10.1%
Club Drugs	0.5%	0.7%	0.6%
Other Hallucinogens	0.1%	0.0%	0.0%
Cocaine/Crack	4.7%	3.7%	4.3%
Methamphetamine	16.7%	36.7%	24.6%
Other Stimulants	0.2%	0.6%	0.3%
Benzodiazepines	0.6%	4.1%	2.0%
Other Sedative-Hypnotics	0.1%	0.9%	0.4%
Inhalants	0.1%	0.0%	0.0%
Over-the-Counter	0.3%	0.1%	0.2%
Total:	1,235	806	2,041

Primary Substance of Abuse by Age Grouping

Fiscal Year 2005 Substance Abuse Admissions
Utah County Division of Substance Abuse

	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Total
Alcohol	37	111	132	91	48	3	422
Marijuana/Hashish	114	177	87	34	5	0	417
Heroin	11	234	66	15	5	0	331
Other Opiates/Synthetics	1	101	72	26	7	0	207
Club Drugs	3	7	1	1	0	0	12
Other Hallucinogens	0	1	0	0	0	0	1
Cocaine/Crack	5	36	21	21	5	0	88
Methamphetamine	13	201	217	63	8	0	502
Other Stimulants	1	2	4	0	0	0	7
Benzodiazepines	0	14	11	13	2	0	40
Other Sedative-Hypnotics	0	1	6	1	0	0	8
Inhalants	1	0	0	0	0	0	1
Over-the-Counter	0	3	1	0	1	0	5
Total:	186	888	618	265	81	3	2,041

Weber Human Services

Primary Substance by Gender
Fiscal Year 2005 Substance Abuse Admissions
Weber Human Services

	Male	Female	Total
Alcohol	26.5%	19.5%	23.7%
Marijuana/Hashish	25.2%	18.5%	22.6%
Heroin	1.0%	1.2%	1.1%
Other Opiates/Synthetics	1.6%	4.0%	2.5%
Club Drugs	0.1%	0.0%	0.1%
Other Hallucinogens	0.2%	0.0%	0.1%
Cocaine/Crack	4.1%	7.5%	5.5%
Methamphetamine	40.4%	46.4%	42.8%
Other Stimulants	0.2%	0.0%	0.1%
Benzodiazepines	0.3%	1.8%	0.9%
Other Sedative-Hypnotics	0.0%	0.8%	0.3%
Inhalants	0.1%	0.0%	0.1%
Other	0.4%	0.3%	0.3%
Total:	1,115	729	1,844

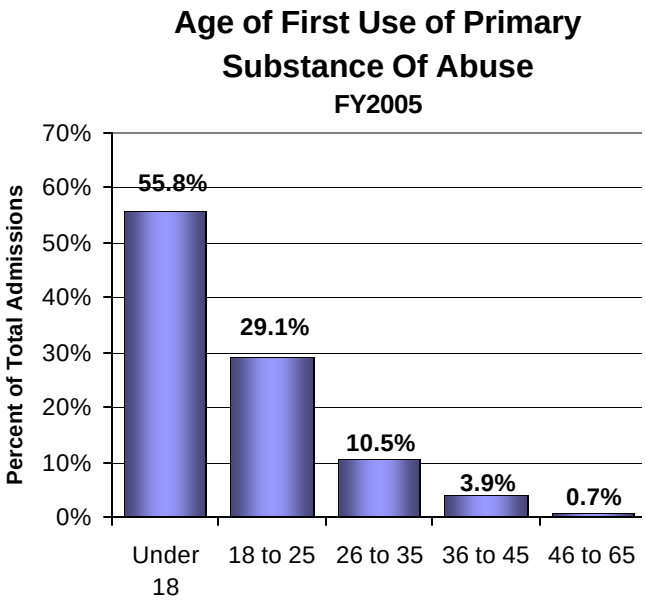
Primary Substance of Abuse by Age Grouping
Fiscal Year 2005 Substance Abuse Admissions
Weber Human Services

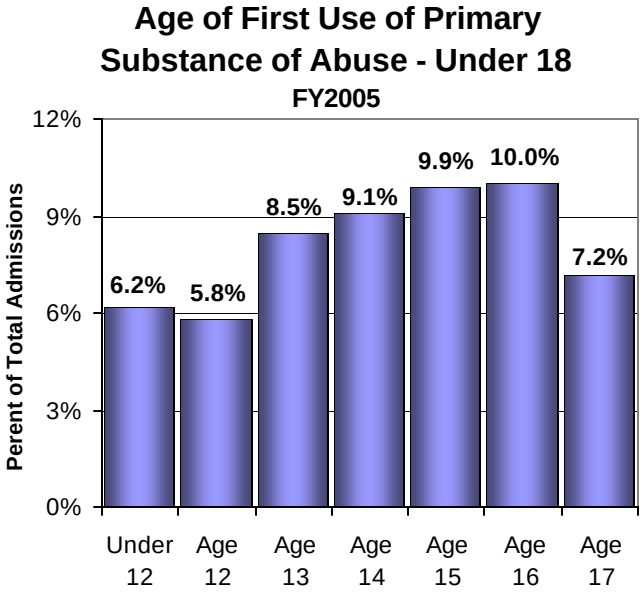
	Under 18	18 to 25	26 to 35	36 to 45	46 to 65	66 and over	Total
Alcohol	76	74	98	110	76	3	437
Marijuana/Hashish	153	129	72	45	17	0	416
Heroin	0	1	5	12	2	0	20
Other Opiates/Synthetics	0	11	15	8	13	0	47
Club Drugs	0	1	0	0	0	0	1
Other Hallucinogens	0	2	0	0	0	0	2
Cocaine/Crack	0	10	36	41	14	0	101
Methamphetamine	34	217	302	196	40	0	789
Other Stimulants	0	2	0	0	0	0	2
Benzodiazepines	0	2	4	6	4	0	16
Other Sedative-Hypnotics	0	0	0	4	2	0	6
Inhalants	1	0	0	0	0	0	1
Other	2	2	1	0	1	0	6
Total:	266	451	533	422	169	3	1,844

Age of First Use of Alcohol and Other Drugs

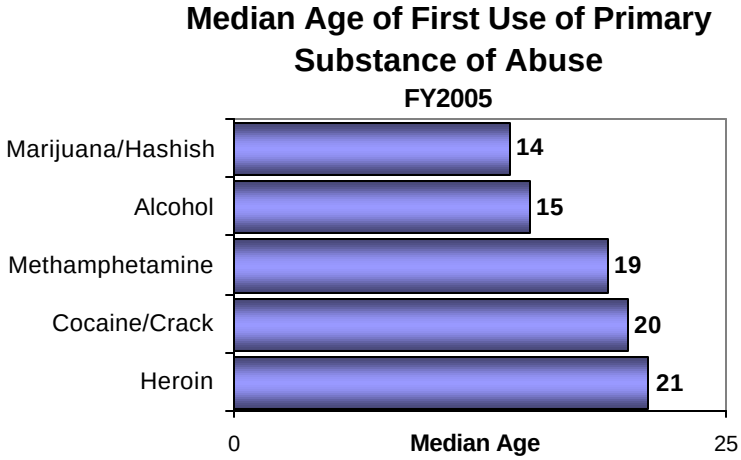
The Division tracks data on age of first use for alcohol and illicit drugs. Early onset of substance use or abuse can help target prevention and intervention services. Understanding age of first use can also help treatment providers with wellness strategies for their patients.

As these graphs illustrate, most use begins in the early teenage years with 56% of first use occuring prior to the age of 18. Still, over one quarter of first use begins in the early adult years (18 to 25), with a significant decrease after that.



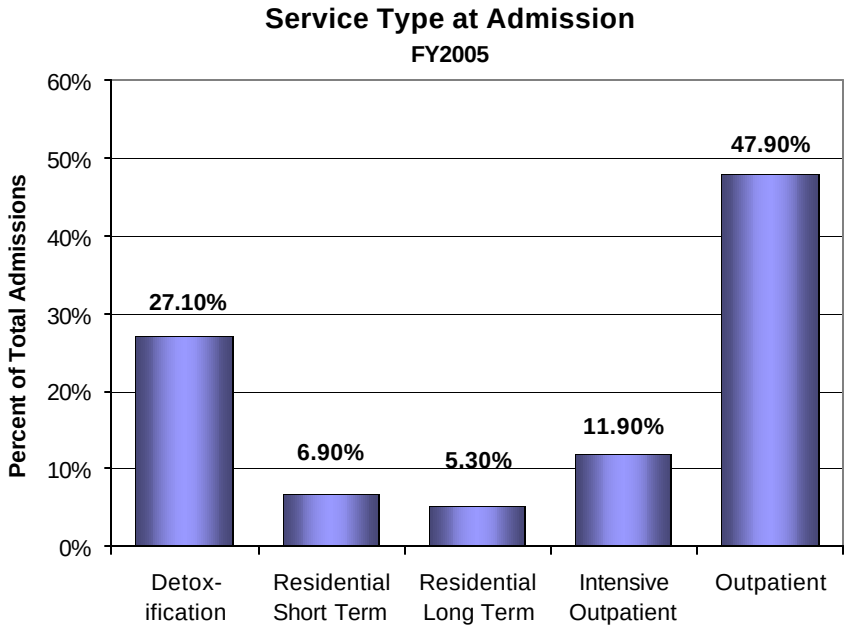


The graph below shows the median age of first use for the patients' primary substance of abuse. This is the age at which half of the patients started before that age and half started after. For marijuana the median age is 14, and for alcohol it is 15. This means half of patients started using in their early teens or before. This highlights the need for early prevention and early intervention efforts.



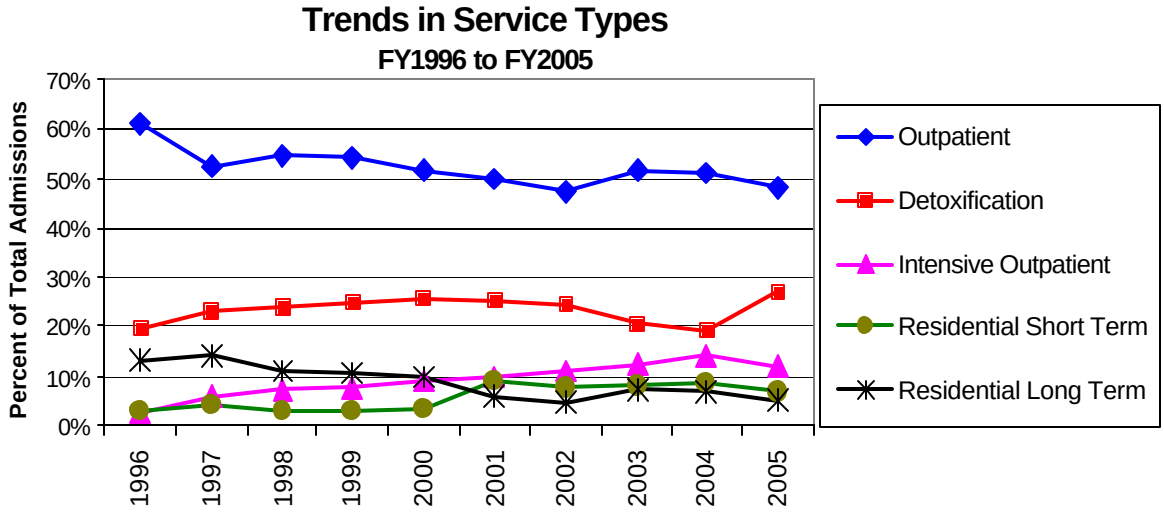
Service Types

The graph below depicts the service type to which patients were admitted upon entering treatment in FY2005. Outpatient is the most widely used service type, followed by detoxification services, which are administered in a variety of settings. Statewide, a small percentage of patients receive services in residential settings. Treatment service type is based on a patient's individual needs and the severity of their situation.



*This graph represents service level capacities and does not address service level needs. Many local authorities do not have sufficient funding to provide the higher costing intensive services, consequently, clients are treated in lower levels of care.

As the graph below shows, the provision for all levels of service has remained somewhat stable over the past seven years. General outpatient services experienced the greatest increase in FY2003. Patients in residential services generally "step-down" to intensive outpatient or outpatient services as they progress through their treatment.



Multiple Drug Use

The table on the right shows the percentage of patients entering treatment who report having problems with more than one substance. At admission, patients report their primary, secondary (if any) and tertiary (if any) drugs of abuse. Multiple drug use at admission averages 54% for the State. Multiple drug use puts the patient at higher risk of negative drug interactions, overdoses, and complications during the treatment process.

Multiple Drug Use
FY2005

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	508	44.5%
Central Utah	100	36.0%
Davis County	317	31.6%
Four Corners	203	42.4%
Northeastern	136	54.6%
Salt Lake County	4,718	47.3%
San Juan County	13	30.2%
Southwest Center	364	59.8%
Summit County	42	16.4%
Tooele County	99	30.7%
U of U Clinic	183	77.5%
Utah County	1,934	94.8%
Utah State Prison	250	74.0%
Wasatch County	90	53.9%
Weber HS	1,329	72.1%
Total:	10,286	54.2%

Injecting Drug Use

Patients Reporting Injecting Drug Use at Admission
FY2005

	# Reporting Injecting Drug Use at Admission	% of Total Admissions for Each Area
Bear River	47	4.1%
Central Utah	11	4.0%
Davis County	138	13.8%
Four Corners	31	6.5%
Northeastern	23	9.2%
Salt Lake County	2,092	21.0%
San Juan County	1	2.3%
Southwest Center	103	16.9%
Summit County	3	1.2%
Tooele County	16	5.0%
U of U Clinic	45	19.1%
Utah County	345	16.9%
Utah State Prison	99	29.3%
Wasatch County	8	4.8%
Weber HS	223	12.1%
Total:	3,185	16.8%

This table shows the number of patients who report intravenous (IV) or non-IV injection (intramuscular or subcutaneous) as the primary route of administration for the substance that led to their need for treatment. The total for the State is 3,185. Salt Lake County reports the highest number at 2,092; although the Utah State Prison reports the highest percentage at 29%. Patients who inject drugs are more likely to have a drug addiction problem and are at higher risk of contracting HIV/AIDS, tuberculosis and hepatitis B and C.

Injecting drug users are a priority population to receive treatment, as required by the Federal Government.

Pregnant Women in Treatment

Pregnancy and prenatal care information is collected on all female patients entering treatment. This information is necessary to plan successful treatment strategies and minimize the chance of complications from prenatal drug and alcohol use, including premature birth and physical and mental impairments. The percentages of females pregnant at admission ranges from 0% in two areas to 7.7% in San Juan County, with a State average of 4.9%.

Pregnancy at Admission
Fiscal Year 2005

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	332	11	3.3%
Central Utah	106	1	1.0%
Davis County	433	Unknown	Unknown
Four Corners	214	9	4.2%
Northeastern	98	2	2.5%
Salt Lake County	3,860	199	5.2%
San Juan County	13	1	7.7%
Southwest Center	271	13	4.8%
Summit County	55	2	3.6%
Tooele County	93	2	2.2%
U of U Clinic	91	3	3.3%
Utah County	806	60	7.4%
Utah State Prison	99	0	0.0%
Wasatch County	43	0	0.0%
Weber Human Services	729	32	4.4%
Total:	7,243	335	4.9%

Patients with Dependent Children

The table below shows the percentage of patients with dependent children and the average number of children in those households. Children with parents who abuse alcohol and/or other drugs are at a higher risk of developing substance abuse problems themselves. The percentage of adult patients with dependent children in Utah is 41%. The average number of dependent children per household with children is 2.21. Northeastern has the highest percentage of patients with dependent children with 81.1%; Southwest has the highest average number of children per household at 2.78.

The table also depicts the percentage of women entering treatment who have dependent children and the average number of children for those households. Northeastern has the highest percentage of females with children at 86.2%; Southwest has the highest average number of dependent children per household at 2.88.

It is important to note that appropriate treatment can greatly impact families. Treatment providers in Utah address the entire family and provide services to children in households where parents or siblings are receiving treatment for drug or alcohol dependence.

Patients with Dependent Children
Fiscal Year 2005

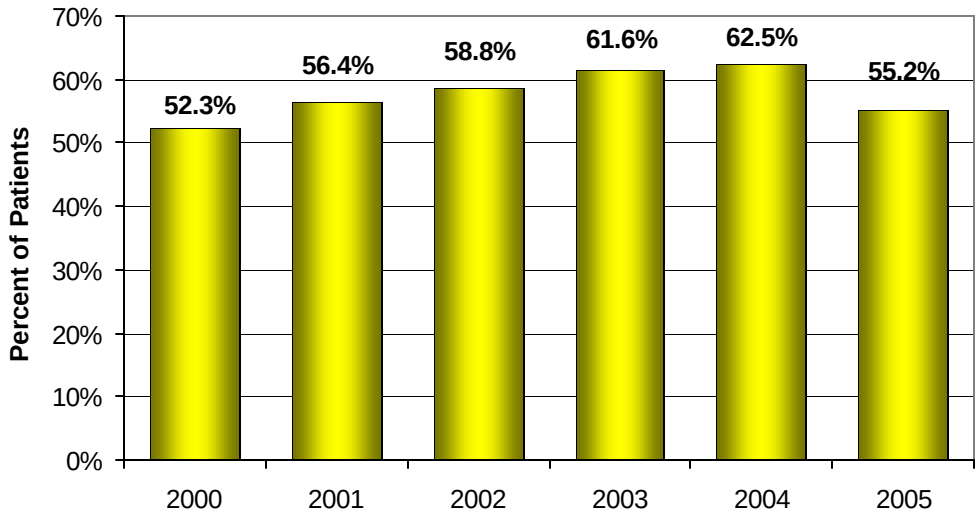
	Percent of all Patients with Children	Average Number of Children (of Patients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	29.5%	2.15	38.3%	2.09
Central Utah	48.2%	2.05	55.7%	2.12
Davis County	54.4%	2.06	65.8%	2.05
Four Corners	47.0%	2.29	59.8%	2.34
Northeastern	81.1%	1.98	86.2%	1.90
Salt Lake County	36.7%	2.15	54.3%	2.20
San Juan County	9.3%	1.75	23.1%	2.00
Southwest Center	57.6%	2.78	71.2%	2.88
Summit County	23.7%	2.31	25.5%	1.85
Tooele County	43.7%	2.17	61.3%	2.35
U of U Clinic	60.6%	2.34	65.9%	2.42
Utah County	47.6%	2.41	64.6%	2.40
Utah State Prison	35.8%	2.23	49.5%	2.24
Wasatch County	56.3%	2.65	62.8%	2.78
Weber Human Services	45.3%	2.10	58.8%	2.22
Total:	41.0%	2.21	56.9%	2.25

Treatment Outcomes

The Division of Substance Abuse and Mental Health collected discharge data on over 18,000 patients in FY2003. The analyses in this section include data for patients who were discharged successfully (they completed the objectives of their treatment plan), and for those patients who were discharged unsuccessfully (they left treatment against professional advice or were involuntarily discharged by the treatment provider because of non-compliance issues). The data in this section also includes patients who have a discharge reason of transfer. The treatment is considered to be successful if a patient continues on in another modality. The data do not include patients who were admitted only for detoxification services or who were receiving treatment while they were incarcerated at the Utah State Prison.

The following graph depicts the percentage of patients discharged in FY2005 who successfully completed their modality of treatment. The rate of success improved consistently from FY2000 until FY2005. The recent decrease in successful completion of treatment is under review.

Percentage of Patients Successfully Completing Treatment Modality
FY2000 to FY2005



When patients are admitted into substance abuse treatment, they complete a comprehensive assessment. This assessment collects the information necessary for determining how to best treat the individual problems that are associated with the patient's addiction. When a patient is discharged from a treatment program, certain aspects of the patient's life are again assessed in order to measure the progress the patient has made in those areas. The following pages present outcome statistics for criminal activity, alcohol and drug use, living arrangement, and employment.

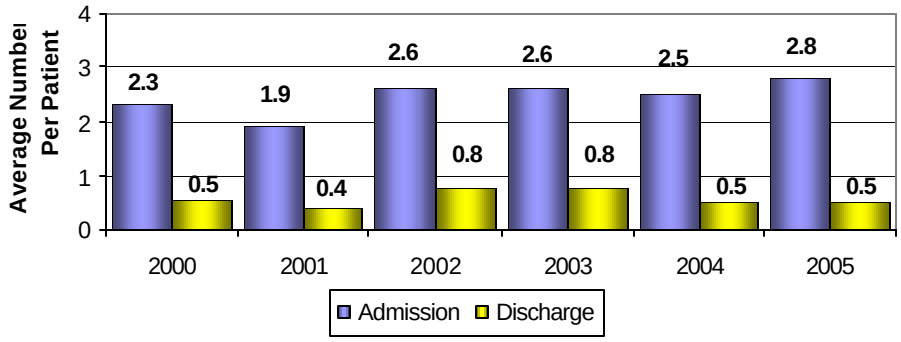
It is important to note that the analyses for these statistics exclude patients admitted for detoxification treatment and those receiving treatment in the Utah State Prison.

Criminal Activity

In fiscal year 2005, during the six months prior to being admitted to treatment services, patients reporting arrests had been arrested an average of 2.8 times. Upon assessment at discharge, very few patients had been arrested again after they entered treatment.

Decrease in Average Number of Arrests (Per Patient With an Arrest History)

FY2000 to FY2005

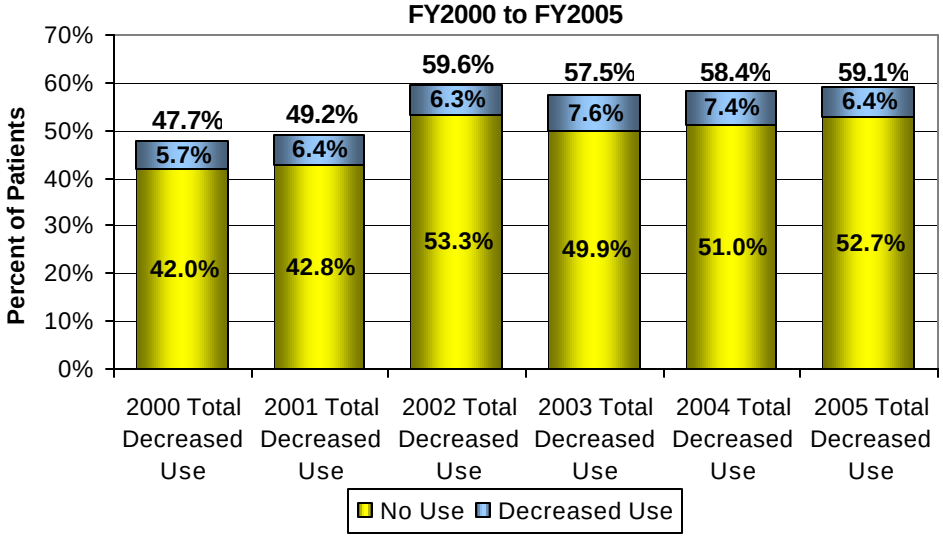


Decrease in Substance Use

The following chart provides information about the substance use patterns of patients in the 30 days prior to entering treatment and again in the 30 days prior to being discharged from treatment. As expected, a large majority of patients entering treatment had been using alcohol or other drugs quite frequently; many of them were using on a daily basis. In FY2005 52.7% reported no 30-day use of their primary substances at discharge. An additional 6.4% reduced their use of alcohol and drugs for a total of 59.1% of patients reporting reduced use.

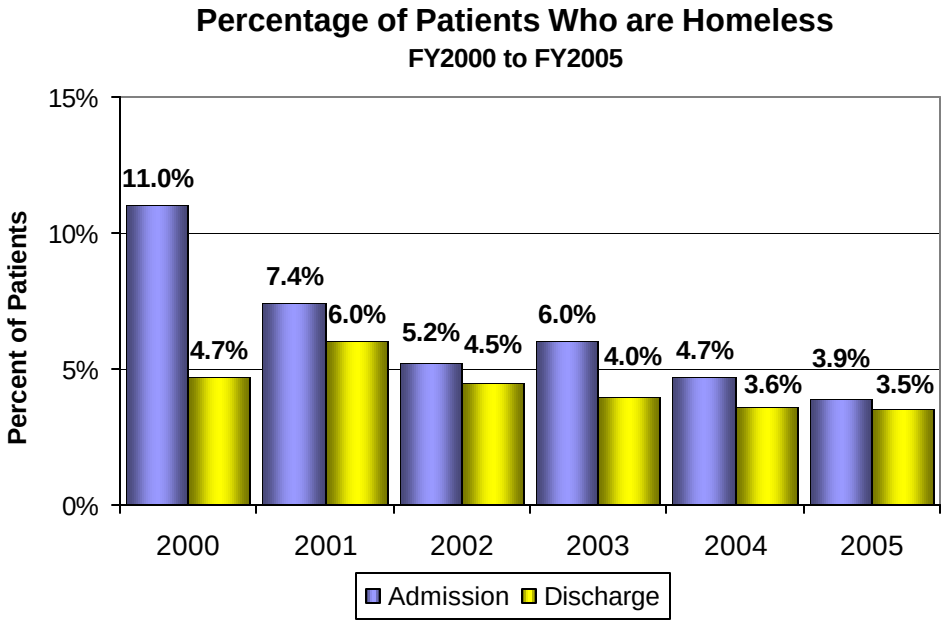
Abstinence and Decrease in Use of Alcohol or Other Drugs at Discharge

FY2000 to FY2005

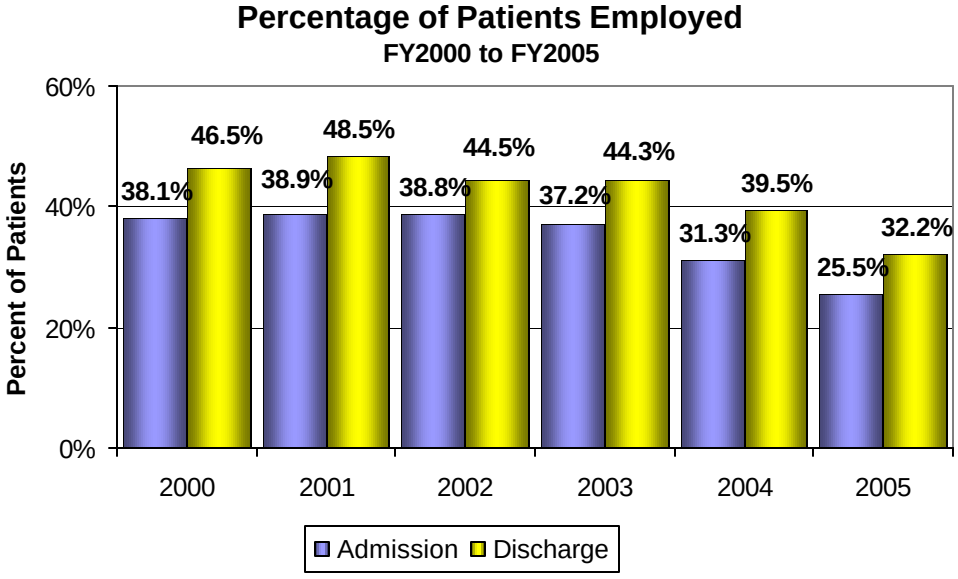


Stability of Patient

As shown in the chart below, 3.9% of patients entering substance abuse treatment in FY2005 were homeless. Being that a stable living environment is a critical element in achieving long-term successful results from substance abuse treatment, the treatment providers across Utah work very hard to assist patients in establishing a more stable living situation. Statistics show that treatment is an important factor in helping the substance abusing population enter more stable living environments.



The employment status of a patient struggling with a substance abuse or dependence problem is another key ingredient in the successful recovery from this problem. For this reason, the improvement of patients from admission to discharge is also tracked in this area. Of those patients discharged in FY 2005, 25.5% were employed at admission and 32.2% were employed at discharge.



Justice Programs

Alcohol and other drugs are major contributors to Utah's crime rate. More than fifty percent of violent crimes, sixty to eighty percent of child abuse and neglect cases, and fifty to seventy percent of theft and property crimes involve drug or alcohol use (Belenko and Peugh, 1998; National Institute of Justice, 1999). Eighty-five percent of Utah's prison population has used illicit drugs or alcohol prior to incarceration. Drug use significantly increases the likelihood that an individual will engage in serious criminal conduct (Marlowe, 2003).

DSAMH has developed a number of innovative programs designed to address the connection between drugs and crime. Drug Court, Drug Board, CIAO and DORA strive to decrease substance use, enhance public safety and reduce recidivism by providing individualized services for the justice population.

Drug Court

Drug Courts offer nonviolent, drug abusing offenders intensive court-supervised drug treatment as an alternative to jail or prison. Treatment services are designed to address both substance use and criminality. Participants are required to submit to frequent, random drug tests. Non-adversarial court hearings are held on a weekly or semi-weekly basis to monitor program compliance. During these hearings, the judge or hearing officer imposes sanctions or rewards consistent with performance. Successful completion of the treatment program results in dismissal of criminal charges, reduced or set aside sentences, or reduced probation time.

Thirty-two Drug Courts are operating in Utah. The Department of Human Services (DHS) funds treatment, case management and drug testing for 9 adult felony drug courts, 4 family/ dependency drug courts and 3 juvenile drug courts. Below is a short description of each model:

Adult Felony Drug Courts: Utah has fourteen functioning Adult Drug Courts, located in Box Elder, Cache, Carbon, Davis, Emery, Millard, Salt Lake, Sanpete, Sevier, Tooele, Uintah, Utah, Washington, and Weber counties. Juab County is currently planning to implement a Felony Drug Court. These programs target non-violent substance abusing adults.

Juvenile Drug Courts: Utah has five Juvenile Drug Courts located in Weber, Davis, Salt Lake, Tooele and Utah Counties. Juvenile Drug Courts provide individually tailored and developmentally appropriate treatment to substance-using offenders. Juvenile Drug Courts use a comprehensive approach that involves the family, and school system.

Dependency Drug Courts: Six Family/ Dependency Drug Courts operate in Utah. These programs are located in Davis, Grand, Salt Lake, Utah, Weber and Washington Counties. Dependency Drug Courts focus on parents whose substance use could result in loss or restriction of parental rights.

Data collected by DSAMH shows that Drug Court:

Participation is Growing

- Thirty-two Drug Courts are now operating in Utah.
- Over 5,000 Utahns have participated in a Drug Court.
- Over 3,000 Utahns have graduated from a Drug Court.
- Sixty-one percent of participants graduate
- Next year, 2,300 Utahans will participate in Drug Court.
- Participants are involved an average of 347 days (Graduates = 389, Unsuccessful Participants = 274).

Increases Employment Rates

- Employment rates increase 14% between admission and discharge.
- In Uintah County, 96% of participants are employed.

Decreases Substance Use

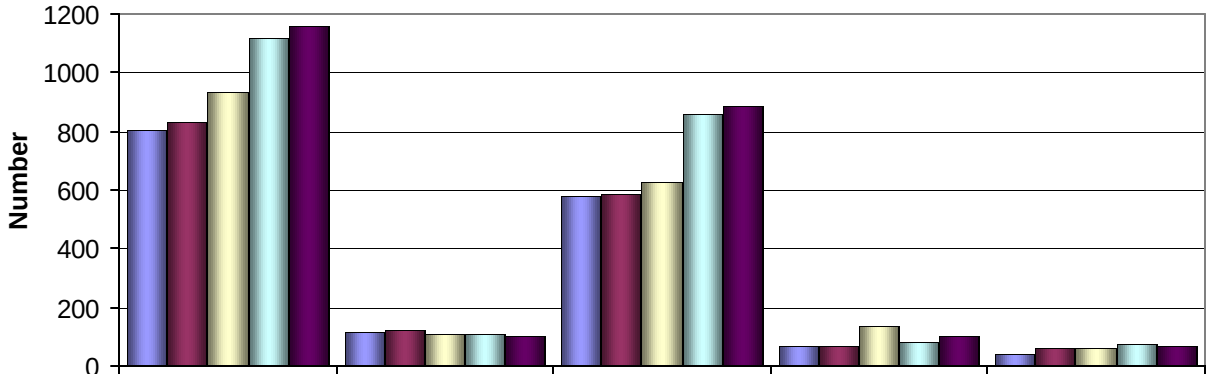
- Eighty-nine percent of all participants report decreased drug use.
- Arrests for drug related offenses decline by 49%.
- Over 90% of drug tests conducted in Felony Drug Court are negative.

Reduces Recidivism

- Arrests for any level of offense decline by 39%.
- Arrests for drug related offenses decline by 49%.
- Six months prior to involvement, participants report an average of 1.9 arrests.
- Seventy-eight percent of participants report zero arrests while in Drug Court.

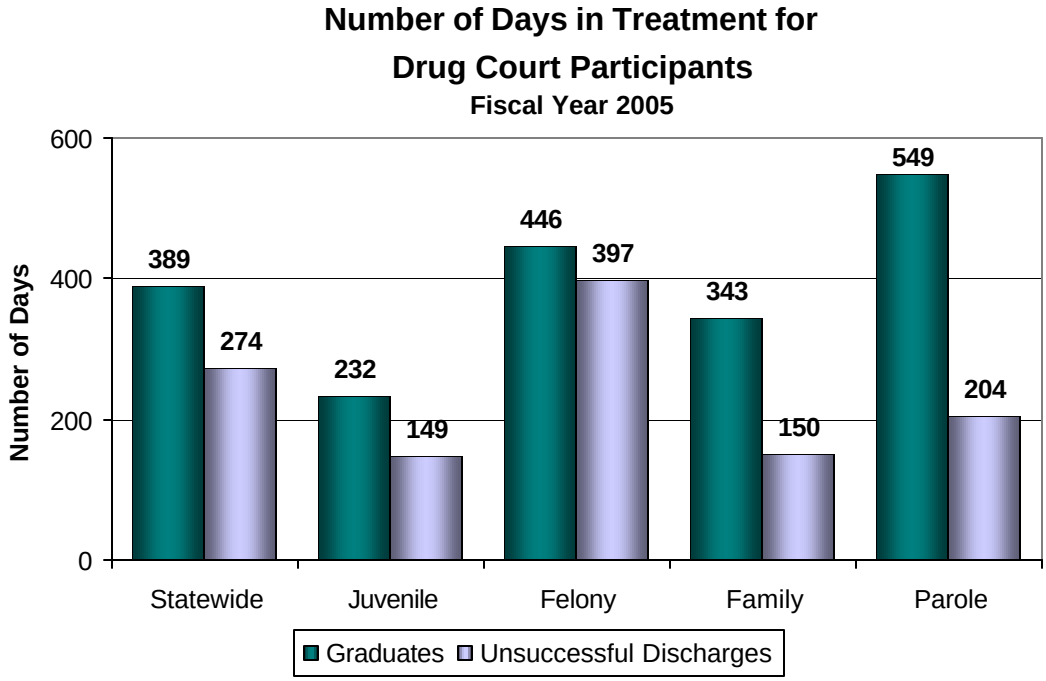
Overall, Drug Court participation has grown in the past five years. However, not all models have report increased participation. As the chart below indicates, Juvenile Drug Court participation has actually declined since 2001.

Drug Court Participants Receiving Services as of:

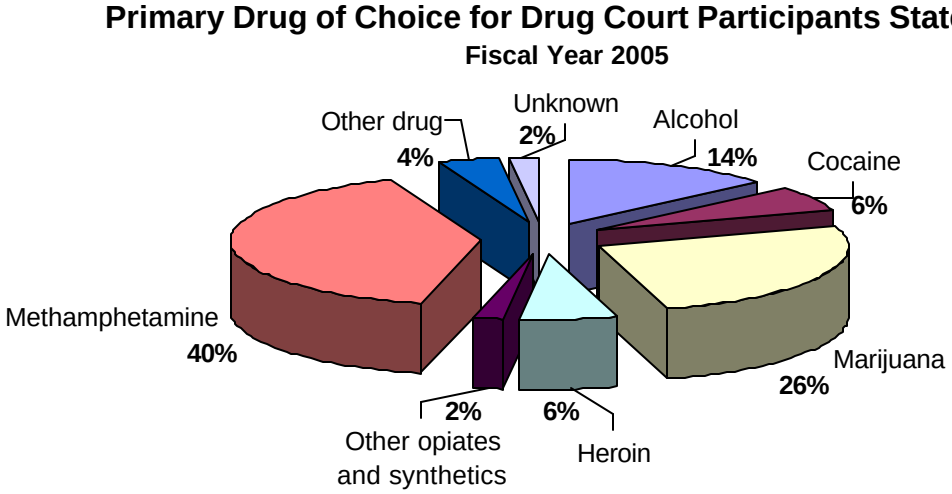


	Statewide	Juvenile	Felony	Family	Parole
July 1, 2001	805	119	579	67	40
July 1, 2002	835	125	585	67	58
July 1, 2003	935	108	628	135	64
July 1, 2004	1121	110	856	82	73
July 1, 2005	1159	103	885	102	69

Drug Courts are effective because they are able to retain offenders in treatment. Retention is the most critical factor in successful outcomes (Marlowe, DeMatteo, & Festinger, 2003). The chart below shows treatment retention by Drug Court Model:



Over 40% of Drug Court Participants reported methamphetamine as their primary drug of choice, compared to 27.6% of the general public treatment population. The chart below provides additional information about drug use among Drug Court participants:



Davis/Weber Drug Board (Parole)

The Davis / Weber Drug Board protects public safety, decreases drug-related crime, and provides effective treatment services to paroles from Utah's prison system. The program accepts parolees from the State prison system who are in need of substance abuse treatment. Parolees in jeopardy of returning to prison due to use of illicit substances are also eligible for this program. Drug Board currently serves over 178 parolees a year.

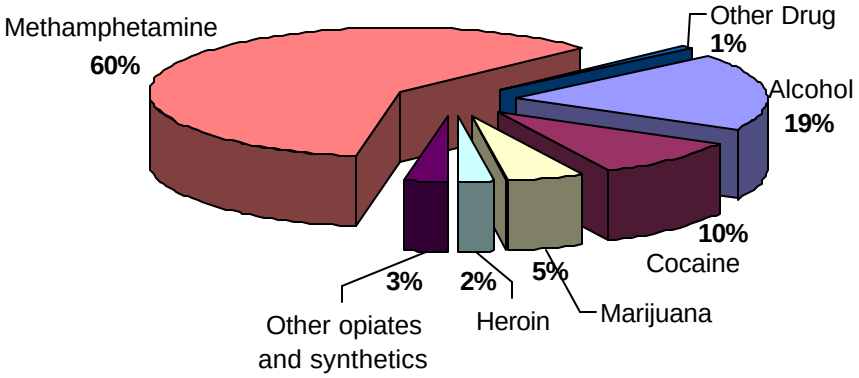
Drug Board participants appear before a Board of Pardons and Parole Hearing Officer every week. Adult Probation & Parole Field Agents conduct home visits and provide case management services. Participants are also required to engage in substance abuse treatment and submit to random urinalysis. Weber Human Services and Davis Behavioral Health provide a full continuum of treatment services; therapy groups focus not only on substance abuse, but also on criminal thinking errors and relapse prevention.

Program accomplishments include:

- 68 parolees have graduated since the program's inception
- 67% of participants obtain full-time employment
- 85% of participants report abstinence from alcohol
- 95% of drug tests are negative for illicit drugs.

At admission, 60% of participants report that their primary drug of choice is methamphetamine. The chart below illustrates drug use among Drug Board participants:

Primary Drug of Choice for Drug Board Participants
Fiscal Year 2005



Collaborative Interventions for Addicted Offenders (CIAO)

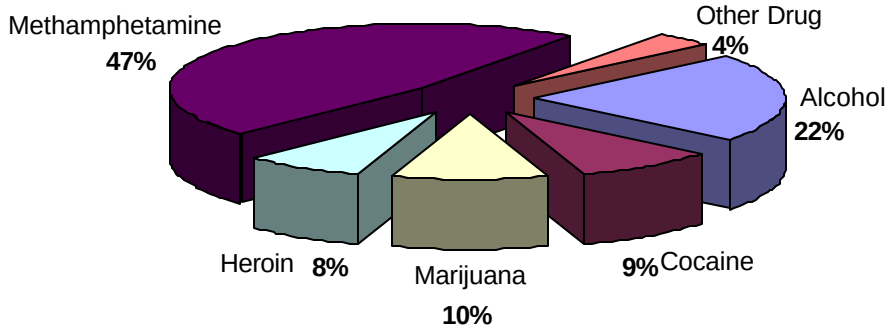
CIAO is a partnership between the Utah Department of Corrections and the Division of Substance Abuse and Mental Health. The program targets parolees and probationers with serious substance abuse issues. In the last three years, CIAO has created an assessment-driven linkage between institutional treatment, transition, community treatment and aftercare for substance abusing offenders.

Since the program' inception:

- 58% of CIAO clients have completed treatment successfully
- Over 1700 offenders have received services
- Employment rates increase by 13% between admission and discharge
- There is a significant reduction in arrests and drug use among participants.

At admission, methamphetamine is the most common drug of choice:

Primary Drug of Choice for CIAO Clients
Fiscal Year 2005



Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA) Pilot Program is one attempt to improve Utah's response to offenders with drug addictions. In 2005, the Legislature appropriated funds for this innovative pilot project in Salt Lake County. The purpose of this pilot is to examine the impact of providing substance abuse screening, assessment and treatment services to Felony offenders. The Graduate School of Social Work at the University of Utah will conduct a professional and independent review of this program.

DORA requires a drug screening and assessment prior to sentencing. Adult Probation and Parole Officers also assess the threat to the community posed by potential clients and, subsequently, provide supervision services specifically designed to reinforce treatment services. Assessment information is shared with Judges prior to sentencing. The screening and assessment provide the Judge with specific information about the offender's substance abuse treatment and supervision needs. Judges then have the choice of imposing prison time or mandating treatment. Additional information about DORA can be found in the Salt Lake County portion of this report.

Recovery Day

September is National Alcohol and Drug Addiction Recovery Month. The month is set aside to recognize the strides made in substance abuse treatment and to educate the public that addiction is a treatable public health problem that affects us all. The observance of Recovery Month lets people know that alcohol and drug abuse can be managed effectively when the entire community supports those who suffer from these treatable diseases.

This year Salt Lake County hosted Utah's 4th Annual Recovery Day on September 17, 2005 at the Gallivan Center. Utah's Recovery Day is an annual celebration for people in recovery and their families. The event is free and includes entertainment, information, food, family activities and crafts and games for kids. This year the event included a 5K "Run for Recovery" hosted by the Utah Alcoholism Foundation.

Participants received information and support during Recovery Day.

A climbing wall, set up and supervised by the Utah National Guard, was a huge hit with kids and adults at Recovery Day.

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MENTAL HEALTH TREATMENT

System Overview

Administration

Under the policy direction of the State Board of Substance Abuse and Mental Health, the Utah Division of Substance Abuse and Mental Health (DSAMH) is the mental health authority for the State of Utah. As such, it is charged with many duties including, but not limited to:

1. Educating the general public
2. Providing consultation, support and assistance to public and private mental health institutions
3. Educating families about mental illness
4. Promoting family involvement in treatment
5. Developing cooperative, working relationships with allied agencies
6. Promoting or conducting research on mental health issues
7. Receiving, distributing and directing public funds for mental health services
8. Monitoring and evaluating local mental health authorities to ensure
    a. A comprehensive continuum of mental health services
    b. Appropriate expenditure of public funds
    c. Governance of quality mental health programs

Local Mental Health Authorities

Under Utah State Statute local mental health authorities are given the responsibility to provide mental health services to their residents. A local mental health authority is generally the governing body of a county. There are 29 counties in Utah, and 13 local authorities for the period covered in this report. Most counties have joined with one or more counties through and inter-local agreement to become a local authority to provide mental health services for their residents. By legislative intent, no community mental health center is operated by the State.

Local authorities contract with community mental health centers (CMHC), which are the service providers of the system. Three of the 13 local authorities, Salt Lake, Summit, and Tooele, have elected to subcontract with Valley Mental Health to provide services. Local authorities not only receive state and federal funds to provide comprehensive mental health services, they are also required by law to provide a 20 percent match of state funds received.

Clinical Oversight and Monitoring

Currently, DSAMH provides clinical monitoring and oversight by, at minimum, annual reviews of each of the 13 local CMHCs. These annual reviews are three pronged. First, site visits to program locations assist the Division in assessing quality care and adequate facilities. Second, records reviews substantiate medical necessity for care, coordinated care, and the documentation of adherence to preferred practice guidelines. Third, clinical staffings between DSAMH staff, CMHC staff and often families or consumers demonstrate the implementation of quality care as evidenced by recovery-driven language and efforts, coordinated care between providers and systems, and consumer/family driven care.

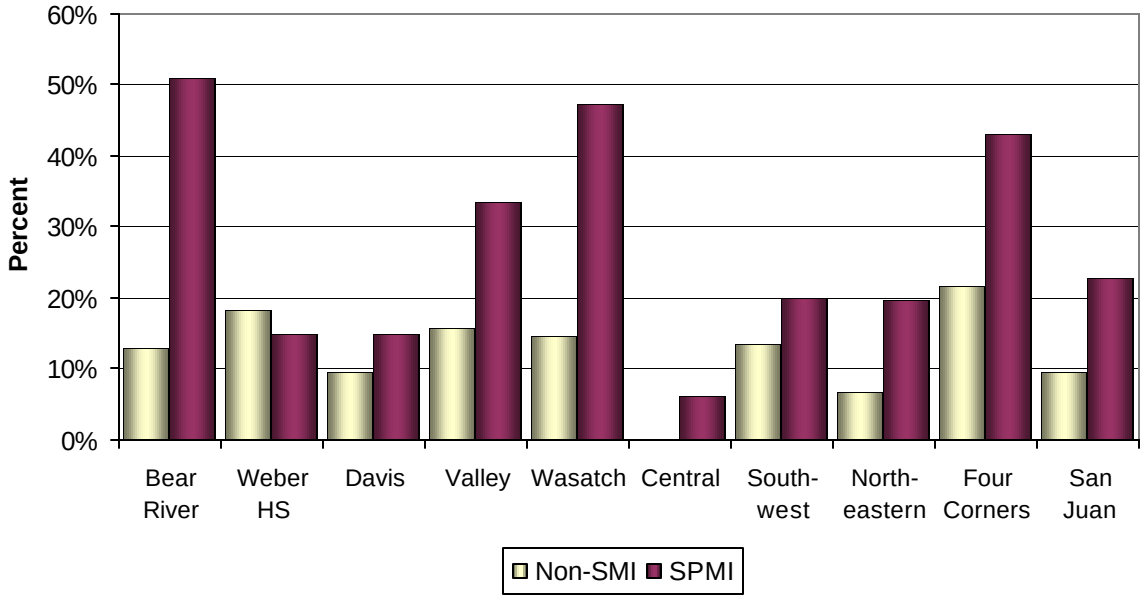
Mental Health Service Delivery

Although each CMHC has consumers with unique needs and each CMHC operates differently, the fundamental process of accessing mental health services begins with a screening or a clinical assessment. When a consumer requests mental health services, the first step is to determine what kind of treatment will be medically necessary and the most effective in helping the consumer with his or her recovery.

This assessment typically occurs between a clinician and a consumer. If the consumer is a youth,

the parent or guardian is also involved in this clinical conversation. From the assessment, a diagnosis is made and the appropriate placement and corresponding services are prescribed. When a consumer is seriously emotionally disturbed or seriously and persistly mentally ill, there are typically more services initially required to assist the consumer with his or her recovery.

Percent of Persons Who Received More Than One Type of Program Service by CMHC, by Non-SPMI and SPMI
Fiscal Year 2005



Levels of Care

Within CMHCs, there are multiple placement opportunities. These placements are referred to as Levels of Care. Most CMHCs have the following levels of care:

1. *Inpatient Treatment:* Comprehensive multi-disciplinary therapeutic services provided within a 24-hour protected environment for the purposes of safety, security, assessment and stabilization of acute behavioral health care emergency or crisis.
2. *Psychiatric Residential Treatment:* Medically supervised living arrangements for clients needing twenty-four hour alternative residential care and ongoing clinical interventions. Clinical interventions typically include individual therapy, group therapy, skill development, case management and medication management.
3. *Therapeutic Day Treatment:* Highly intensive and structured services provided to stabilize clients experiencing acute episodes of behavioral health disorders, when there is no imminent threat of harm to themselves or others. Clinical services consist of intensive, short-term interventions.
4. *Outpatient Treatment:* Provided to assess, stabilize, and treat clients at the least restrictive level of care for the purpose of reducing current behavioral health symptoms and/or maintaining an adequate level of functioning. Services may include individual therapy, group therapy, medication management, psychological assessment , skill/behavioral development and case management.
5. *Psychosocial Rehabilitation Services:* Designed to maintain client functioning in the non-acute phase of a long-term disorder to reduce the risk of the development of acute

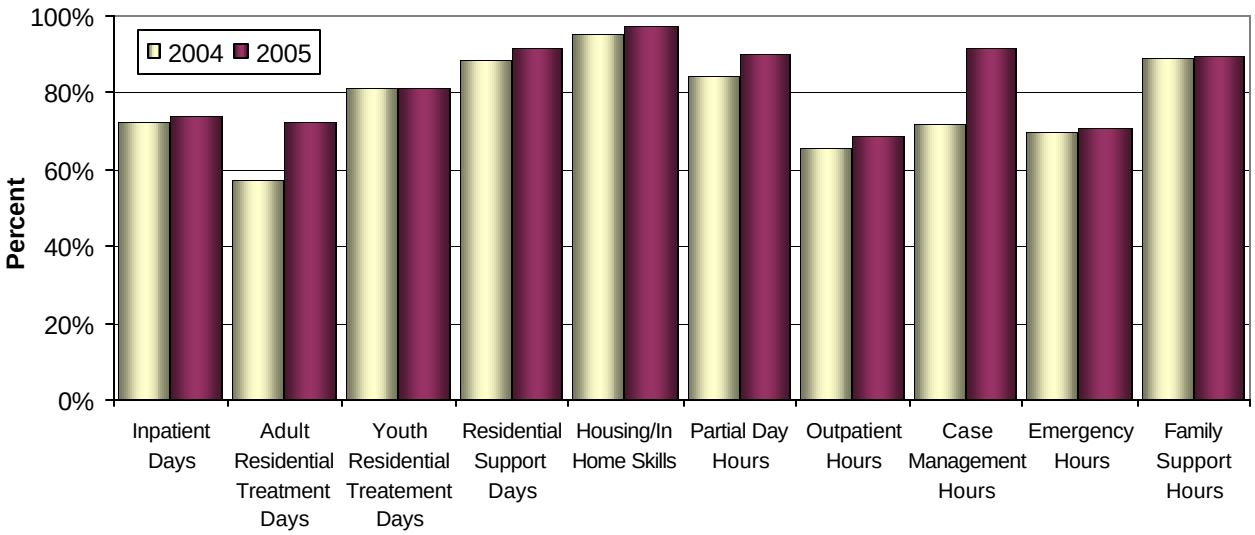
symptoms requiring a more restrictive level of care or as an intervention to maintain or improve habilitation skills. These skills include basic daily living skills of cooking, budgeting, hygiene, scheduling, etc. These skills help consumers manage and function in the community.

6. *Emergency/Crisis Services:* Services provided to assess for and stabilize a consumer at imminent risk of harm to self or others.

The following two charts depict the types and percentages of services for treating consumers who are seriously emotionally disturbed or severely and persistently mentally ill. Please note that the most frequently needed services are those community services that facilitate recovery by keeping the consumer in his or her community setting.

Of All People Who Received a Particular Mental Health Program, What Percent of Them are SPMI/SED*

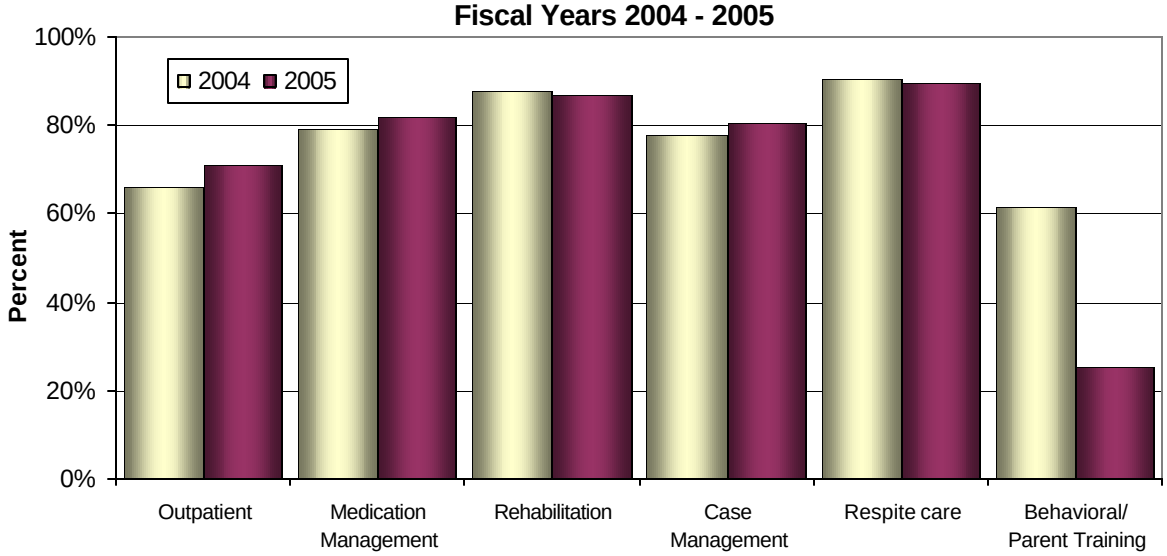
Fiscal Years 2004 - 2005



*Within each program type, clients are unduplicated, however, between programs clients are duplicated.

Of All People Who Received a Particular Mental Health Program, What Percent of Them are SPMI/SED*

Fiscal Years 2004 - 2005



*Within each program type, clients are unduplicated, however, between programs clients are duplicated.

The table below shows the percentage of consumers who have been treated at various levels of care according to the stated diagnoses.

Diagnosis for Mental Health Patients by Age Grouping
Fiscal Year 2005

	Under 12	13 to 17	18 to 35	36 to 65	66 and over
Abuse	14.9%	5.4%	2.5%	1.0%	0.3%
Adjustment Disorders	20.7%	9.9%	4.7%	3.0%	4.5%
Anxiety Disorders	12.0%	8.4%	9.1%	8.8%	7.7%
Attention Deficit	19.0%	12.0%	2.1%	0.7%	0.1%
Bipolar	1.7%	3.9%	8.8%	11.6%	8.6%
Depressive Disorders	7.4%	24.3%	27.0%	32.6%	49.7%
Diagnosis Deferred	2.0%	3.7%	6.1%	4.2%	2.5%
Mental Retardation	6.5%	2.0%	0.7%	0.3%	0.1%
Oppositional Defiant Disorder	7.4%	7.4%	0.3%	0.0%	0.0%
Other Childhood	7.4%	7.0%	0.8%	0.3%	0.1%
Schizophrenia	0.2%	1.4%	10.0%	19.2%	16.9%
Substance Abuse	0.1%	11.3%	25.5%	15.5%	1.6%
Other	0.6%	3.4%	2.4%	2.8%	7.8%

Treatment

In developing a treatment philosophy, the Division of Substance Abuse and Mental Health (DSAMH) anchors its endeavors within the framework of recovery and systems of care. As DSAMH contracts with local mental health authorities to provide services to Utah consumers, it is mindful of the following principles when monitoring local programs.

- Treatment is provided in the least restrictive setting, is consumer driven, and family oriented
- Treatment occurs in strength-based systems and is culturally competent
- Partnerships between providers, consumers, families and other natural supports exist
- Treatment develops, encourages and sustains hope

Hope…is not the same as joy that things are going well…It is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out…It is also this hope, above all, which gives us the strength to live…."
-Vaclav Havel, 1986

It is DSAMH's vision that local programs are developing resiliency and facilitating recovery with their consumers as they provide the following mandated services:

- Inpatient Care
- Residential Care
- Outpatient Care
- Twenty-four Hour Crisis Care
- Medication Management
- Psychosocial Rehabilitation
- Case Management
- Community Support
- Consultation and Education Services
- Services to Persons Incarcerated in a County Jail or Other County Correctional Facility

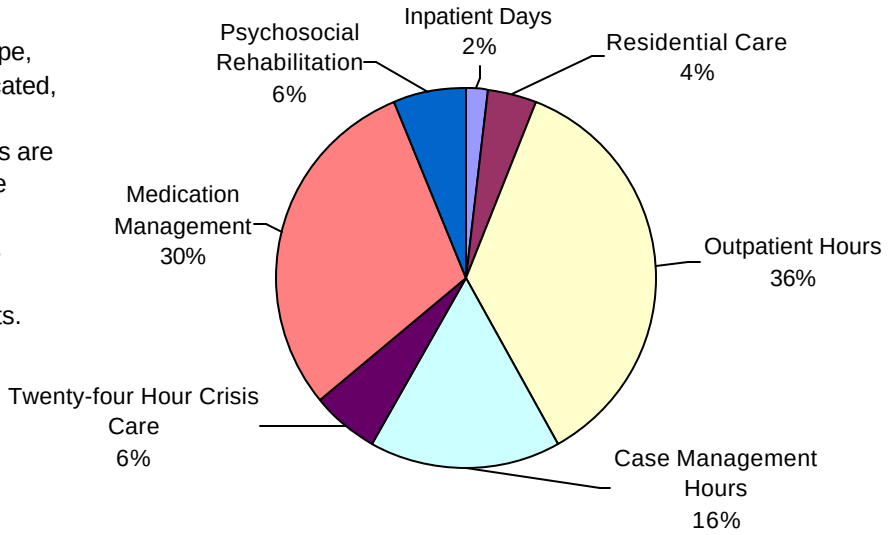
The following charts and tables show both the percent of resources CMHCs have deployed to providing eight of the ten mandated services, as well as the percentage of primary diagnoses within each service. Data for correctional facilities and education services is not available.

For adults, the majority of service resources occur within the case management and medication management domains. Of the consumers receiving outpatient services, 68.8% carry a diagnosis of schizophrenia; this is also the primary diagnosis at inpatient units (32.8%).

Percentage of Adults Receiving Each Type of Program/Service*

Fiscal Year 2005

*Within each service/program type, adults are unduplicated, between program/ service types adults are duplicated. This pie chart shows which services/ programs serve the most unduplicated clients.



Percentage of Adults Who Received Each Service/Program by Diagnosis*

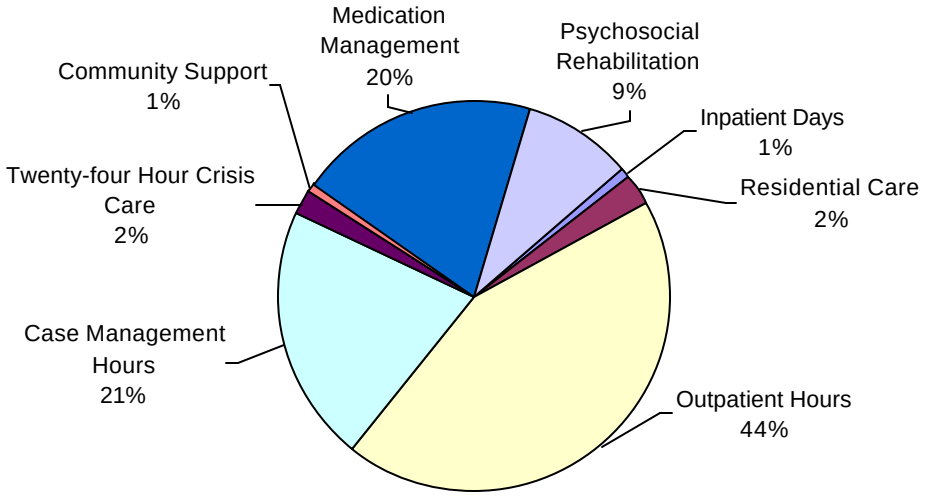
Fiscal Year 2005

	In-patient Days	Resi-dential Care	Out-patient Hours	Case Manage-ment Hours	Twenty-four Hour Crisis Care	Comm-unity Support	Medi-cation Mgmt.	Psycho-social Rehab-ilitation
Abuse	0.2%	0.4%	3.1%	1.7%	0.9%	0.2%	0.2%	0.3%
Adjustment Disorders	1.2%	0.9%	0.0%	3.8%	2.1%	2.5%	1.4%	0.9%
Alzheimers and Organic Brain Disorders	0.8%	0.4%	3.1%	1.4%	1.2%	0.7%	1.5%	0.8%
Anxiety Disorders	4.0%	2.6%	0.0%	8.9%	8.7%	6.1%	9.2%	4.7%
Attention Deficit	0.3%	0.5%	0.0%	1.3%	1.1%	0.8%	1.5%	0.8%
Bipolar	14.3%	9.4%	15.6%	10.1%	12.1%	13.6%	15.0%	10.8%
Conduct Disorder	0.0%	0.1%	0.0%	0.1%	0.1%	0.2%	0.0%	0.2%
Depressive Disorders	22.5%	13.4%	3.1%	31.0%	32.8%	28.1%	33.0%	19.9%
Diagnosis Deferred	15.3%	3.4%	0.0%	3.7%	1.9%	10.1%	1.4%	2.2%
Mental Retardation	0.1%	0.1%	3.1%	0.5%	0.5%	0.4%	0.5%	0.5%
Oppositional Defiant Disorder	0.1%	0.0%	0.0%	0.1%	0.1%	0.2%	0.1%	0.1%
Other	1.3%	0.9%	0.0%	3.4%	1.7%	1.8%	1.6%	1.4%
Other Childhood	0.3%	0.4%	0.0%	0.4%	0.4%	0.3%	0.4%	0.3%
Personality Disorders	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%
Schizophrenia	32.8%	34.8%	68.8%	14.6%	22.7%	24.8%	26.5%	35.7%
Sexual/Gender Disorders	0.0%	0.1%	3.1%	0.1%	0.1%	0.1%	0.1%	0.2%
Substance Abuse	6.8%	32.5%	0.0%	18.9%	13.5%	10.1%	7.6%	21.0%

*Within each service/program type, adults are unduplicated, between program types adults are duplicated. This table should be read as "22.5% of adults who received an inpatient day in fiscal year 2005 were diagnosed with a Depressive Disorder."

For children and youth, the majority of services happen in the outpatient clinic followed by case management and medication management. It is interesting to note that in children and youth, the most prevalent primary diagnosis in the top 3 service mandate areas is ADHD followed closely by one of the depressive disorders. Of the children and youth admitted to an inpatient unit, 31.6% have a depressive disorder diagnosis.

Percentage of Youth/Children Receiving Each Type of Program/Service
Fiscal Year 2005



*Within each service/program type, youth are unduplicated, between program/service types youth are duplicated. This pie chart shows which services/programs serve the most unduplicated clients.

Percentage of Youth Who Received Each Service/Program by Diagnosis*
Fiscal Year 2005

	In-patient Days	Resi-dential Care	Out-patient Hours	Case Manage-ment Hours	Twenty-four Hour Crisis Care	Comm-unity Support	Medi-cation Mgmt.	Psycho-social Rehab-ilitation
Abuse	0.9%	8.5%	10.5%	6.9%	4.0%	2.1%	3.8%	5.9%
Adjustment Disorders	4.7%	5.3%	15.6%	13.9%	8.6%	14.0%	6.0%	8.7%
Alzheimers and Organic Brain Disorders	0.0%	0.0%	0.1%	0.2%	0.0%	0.0%	0.2%	0.1%
Anxiety Disorders	7.9%	7.2%	10.1%	12.5%	8.2%	18.1%	10.4%	9.9%
Attention Deficit	14.0%	10.2%	15.6%	17.6%	17.8%	23.8%	31.4%	17.2%
Bipolar	6.0%	4.9%	2.5%	3.7%	6.8%	8.3%	6.0%	4.4%
Conduct Disorder	2.3%	6.0%	1.8%	2.3%	2.2%	0.5%	1.9%	3.3%
Depressive Disorders	31.6%	18.0%	14.0%	14.8%	22.0%	14.5%	17.0%	11.7%
Diagnosis Deferred	2.8%	0.2%	2.5%	1.3%	6.4%	0.0%	0.4%	0.7%
Mental Retardation	2.3%	2.3%	4.0%	3.1%	6.4%	2.6%	4.0%	10.6%
Oppositional Defiant Disorder	5.1%	5.8%	7.2%	8.3%	6.8%	6.7%	7.9%	7.8%
Other	1.9%	16.9%	5.2%	4.2%	0.8%	1.0%	2.6%	5.9%
Other Childhood	4.7%	3.7%	5.1%	5.1%	5.0%	6.7%	4.4%	4.6%
Personality Disorders	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%
Schizophrenia	6.0%	1.9%	0.7%	1.1%	2.8%	1.6%	1.5%	1.5%
Sexual/Gender Disorders	0.0%	0.7%	0.0%	0.1%	0.0%	0.0%	0.1%	0.3%
Substance Abuse	2.8%	8.5%	4.8%	5.0%	2.4%	0.0%	2.3%	7.4%

*Within each service/program type, youth are unduplicated, between program types adults are duplicated. This table should be read as "22.5% of adults who received an inpatient day in fiscal year 2005 were diagnosed with a Depressive Disorder."

Recovery

Recovery from mental illness was once thought impossible and hope for recovery was thought to be unreasonable. Over the last two decades, however, much work has been done that demonstrates recovery is not only possible, it is expected and it is real. Dr. Daniel Fisher lists the following as attributes of a person who has recovered from mental illness:

1. Makes their own decisions in collaboration with other supportive people outside the mental health system
2. Has a meaningful and fulfilling network of friends outside mental health professionals
3. Has achieved a major social role/identity other than consumer (such as student, parent, worker)
4. Medication is one tool among many freely chosen by the individual to assist in their day to day life (used as the chronically normals use medication)
5. Capable of expressing and understanding emotions to such a degree that the person can cope with severe emotional distress without it interrupting their social role and without them being labeled symptoms
6. A Global Assessment of Functioning Scale score of greater than 61: "functioning pretty well, some meaningful interpersonal relationships and 'most untrained people would not consider him sick'"
7. Sense of self is defined by oneself through life experience and interaction with peers

William Anthony, Director of the Boston Center for Psychiatric Rehabilitation (1993) states recovery is

" a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

In 2003, the federal government produced a document referred to as "Transformation," or "The President's New Freedom Commission on Mental Health." DSAMH supports the six Transformation goals:

1. Americans understand that mental health is essential to overall health
2. Mental health care is consumer and family driven
3. Disparities in mental health services are eliminated
4. Early mental health screening, assessment, and referral to services are common practice
5. Excellent mental health care is delivered and research is accelerated
6. Technology is used to access mental health care and information

At the heart of both recovery and resiliency is the principle of hope. As the community mental health centers strive to develop resiliency and facilitate recovery with their consumers, DSAMH will provide consultation and technical assistance, offer regional trainings, and develop standardized indicators of resiliency and recovery within systems of care. In addition, DSAMH will seek to recognize mental health treatment that meaningfully adapts the principles of recovery and resiliency.

Pre-Admission Screening/Resident Review (PASRR)

Under current Federal Law and Utah Rule, the State Division of Substance Abuse and Mental Health, as the State Mental Health Authority, is required to manage the PASRR Program for preadmission screening and resident review of any individual considered to have a serious mental illness. PASRR is part of the Federal Omnibus Budget Reconciliation Act. The rules regarding the PASRR process are found in the Code of Federal Regulations Part 483, Subpart C, Volume 57, No. 230. This federal law was enacted for three purposes:

- To ensure that people with mental illnesses in Medicaid-funded nursing homes are being adequately diagnosed and treated
- To ensure that those with mental illness or a developmental disability only (and no substantial physical problems), are not being warehoused in nursing homes
- To insure that the federal government is not paying for long term care of the mentally ill or developmentally disabled in nursing homes

The PASRR process consists of two evaluations: Level I and Level II. The Level I contains demographic information, medical, psychiatric and developmental diagnoses, and is provided prior to admission on every resident. It also serves to document when and if a Level II assessment is needed and is requested.

The PASRR Level II evaluation is an in-depth review of medical, social, and psychiatric history, as well as Activities of Daily Living (ADL) functioning. It also documents nursing care services that are required to meet the person's medical needs. This comprehensive evaluation is funded by federal money, which is managed separately by State mental health and developmental disability authorities. There is no charge to the patient.

There are advantages to the patient because of the PASRR process. First, he/she receives an in-depth evaluation of his/her psychiatric status, which is reviewed by a medical prescriber. This service is provided at no cost to the patient. Second, recommendations made in the Level II evaluation are closely monitored by the State Bureau of Medicare/ Medicaid Program Certification and Resident Assessment, which provide oversight and approve payment to the nursing facility from Medicaid. This helps to ensure better care and monitoring by staff in the nursing facility.

The need to complete the PASRR process is fairly specific and all nursing facilities that accept Medicaid as a primary payment must complete a Level I evaluation on every resident, regardless of how the individual resident will be paying for his/her nursing facility stay.

In the past several years the number of PASRR evaluations has increased significantly, from 1080 evaluations in fiscal year 2001 to 1584 in fiscal year 2005, representing an average increase of 100 additional evaluations per year.

Utah has the sixth fastest growth rate in the nation for people age 65 and older. The dramatic growth of the senior population may have significant impact on the PASRR Program as the number of PASRR evaluations will continue to increase with the need for higher level of medical services that require Nursing Facility placements.

Project RECONNECT

Utah's Project RECONNECT is devoted to developing, implementing and sustaining a comprehensive transition program for youth and young adults with serious emotional disturbances and serious mental illnesses. The overarching goal of Project RECONNECT is to mobilize and coordinate community resources to assist youth, between the ages of 14 and 25, with emotional disturbances or emerging mental illnesses to successfully transition into adulthood and achieve full potential in life.

Project RECONNECT is located in counties in the northern and far southern parts of the state. DSAMH contracts with five community mental health centers (CMHCs) to provide services in seven counties: Summit, Salt Lake, Tooele, Davis, Weber, Morgan, and Wasatch. The four CMHCs are Valley Mental Health, Davis Behavioral Health, Weber Human Services, Southwest Behavioral Health Center, and Wasatch Mental Health. The project provides transitional services by establishing the "Transition to Independence Process (TIP)" system within the existing mental health service delivery structure. Facilitators are employees of CMHCs and these centers are responsible for integrating the Project RECONNECT Manual, Ansell-Casey Life Skills Assessment (ACLSA) and the TIP model into agency operation.

Project RECONNECT conducts an annual evaluation process that documents fidelity of the program to the program model, monitors activities engaged in by the site to overcome policy barriers to the sustainability of the program, and advocates for change in policies that have occurred as a result of the program's efforts.

The following are some of the most significant outcomes for 2005:

- 67% decrease in homelessness.
- 53% increase in full-time employment and a 47% increase in part-time employment.
- 50% increase in post-secondary education.
- 82% reduction in criminal activity, with a 100% reduction in arrests.
- 81% decrease in suicide attempts.
- 71% reduction in psychiatric hospitalizations.

"Project Reconnect is the best thing I've ever done. It's helped me get back in touch with the world and the community. Work and school are now the most important parts of my life."

(20 year-old Reconnect consumer with a nine-year history of residential and intensive day-treatment services.)

Ten Year Plan to End Chronic Homelessness

President Bush established a goal of ending chronic homelessness in ten years. Utah developed a plan, adopted March 2005, that focuses on the chronically homeless. The Division of Substance Abuse and Mental Health (DSAMH) is actively participating in working to help implement this plan and alleviate the devastating impact homelessness has on people with mental illness and substance abuse issues.

Utah's Vision Statement

"Every person will have access to safe, decent, affordable housing with the needed resources and support for self-sufficiency and well-being."

- People who are homeless are people - they are people with dreams
- People with serious mental illness and/or co-occurring substance use disorders are often homeless - they can and do recover
- Homeless people should be given real choices in housing, treatment, and supportive services
- In working with the homeless, we must create hope–hopelessness breeds helplessness and despair

In 2005, an estimated 14,000 people were homeless in Utah - 5,565 are families and 2,830 are chronically homeless. Chronic homelessness is defined as an unaccompanied individual with a disabling condition, homeless for one year, or four times in three years.

People who are chronically homeless are:

- High consumers of homeless resources, using at least 50% of all resources allocated for all homeless people, including expensive community emergency services (emergency rooms, jails, etc.)
- A population of whom 39% live with mental illness
- A population of whom 30-35% live with substance abuse disorders

Utah's present practice is to provide shelter, transitional housing, and then permanent housing with the expectation the homeless must accept treatment in order to have any type of housing. A new initiatitve, the "Housing First" policy, supports first housing a person/family and then bringing services to them as a "wrap around" service, as they choose to participate.

Over the past year, Utah prepared a plan to end, not manage, chronic homelessness by 2014. This plan includes the "Housing First" approach for the homeless that separates treatment from housing and improves access to mainstream resources, such as Social Security Benefits, Medicaid, and Food Stamps. The plan also includes policy to close the "front door" of homelessness through effective planning of discharge from public institutions and opens the "back door" to end homelessness by increasing the availability of affordable housing. The State will also track and report results against outcome measures working to end chronic homelessness.

Utah's Transformation Child and Adolescent Network (UT CAN)

In 2005, the Utah Division of Substance Abuse and Mental Health received a federal grant to implement UT CAN (Utah Transformation of Child and Adolescent Network). The mission of UT CAN is to transform Utah's mental health and substance abuse infrastructure so it can develop, expand, and sustain a continuum of effective mental health and substance abuse services for Utah's children and youth. This infrastructure will deliver effective, coordinated, and accountable services. Multiple government and private entities, as well as community members, are involved in the development and implementation of this project. Member representation includes mental health, substance abuse, education, child welfare, juvenile justice, health, ethnic/racial communities, parent organizations, and youth.

UT CAN is grounded in the President's New Freedom Commission on Mental Health Report. The project will approach infrastructure transformation from two levels - state and local. Through Strategic planning, consensus building, and community mobilization, UT CAN will design a statewide master plan of infrastructure transformation that consists of four core components, 1) improved practice field, 2) technology/data, 3) financing structure, and 4) planning/governance/system management.

At the local level, each of the 13 Community Mental Health/Substance Abuse Centers in Utah will meet with community partners to determine their individual community priorities. Once the community stakeholders have identified their greatest community need, DSAMH will fund a small pilot project designed to address each community's individual need.

In September, 2009, when the federal funding for UT CAN ends, the following objectives will have been met:

- The development of a statewide master plan for a transformed child and adolescent MH/SA infrastructure that consists of four core components: practice field, technology/data, financing, and planning/governance/system management
- The development of local infrastructure transformation plans at the community MH/SA centers that have prioritized needs and strategized implementation approaches
- The implementation of a statewide master plan and the provision of technical assistance to community MH/SA centers to implement and sustain local infrastructure transformation plans
- The ability to measure effectiveness of the transformed infrastructure through the implementation of community pilot projects

In order for UT CAN to be successful, DSAMH must first facilitate the development of partnerships between youth, families, public and private agencies; second, join with partners in developing strategies to solve complex treatment needs in times of limited resources; and third, contribute toward the building of infrastructures from the State level that will assist local communities in solving the unique needs of each community.

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CONSUMER SATISFACTION

Voices of Consumers

The quotes from this page are from interviews with patients, staff, and family members at the Utah State Hospital on December 23, 2005. As the interviewers were leaving the hospital unit, a patient named Julie was asked about her feelings and thoughts regarding Hope and Recovery. She was sitting by her self in another room. Her only response to the inquiry was a smile as she said, "I Hope I Recover." DSAMH hopes that all consumers have the same belief.

What does Hope and Recovery mean to you?

"Getting back fully – medically, physically. Hope is the driving force. I know (recovery) by the way I think and feel."

- Val

"Hope is not up being on the mountain top, screaming and jumping with joy; it is when one is in the deepest, darkest valley and can still see the mountain top. When I'm in recovery from substance abuse, mental illness, trauma, or physical pain, I have coherency in life, I may not be able to do exactly what I'm thinking, but I can keep better track of my thoughts….use reality based skills. I have something to hold on to – it's a way of life that I know works for me. I goof up every once in a while, but I keep trying."

- Craig

"It means I have something to look forward to – eternal life, romance, money, a good doctor's visit. The road to recovery is filled with hope. If you didn't have hope all of the time you would quit existing – you always had what you always needed, otherwise you wouldn't exist. Writing fixes me right up."

- Don

"Before I came here I couldn't see an end to it all – not being able to change and lead a normal life – I just saw black and white. I have glimmers of hope and having a better life with family and friends. Being here has kept me safe. Helping others here helps me; I try to do one nice thing a day. Recovery is a lifelong process – it's ongoing. The destination is the journey."

- Karen

"Working with the techs helps me….relationships, marriage, being with your religion, loving one another and sharing with one another…continue to take medications….work on long-term goals."

- Stephen

"Being able to know I will get out of here sooner or later and never come back – getting back to a normal life and not having a loss of independence."

- Scott

"Patients find hope when they realize there is a way back to a normal life which can be achieved by giving options and reinforcing positive behavior. Recovery works best when people are given a view of something better than where they are currently."

- Matt

"We always hope the patient will be able to do the best they can and be able to go home or somewhere other than the hospital. We hope they will stay out, take their medications, talk to their doctors, call us if they need to, and not use substances or alcohol. The more groups and patient involvement the better.

- Ted

"Hope is the belief in recovery."

- Peter's Mom

Statewide Report on Consumer Satisfaction

Overview

In 2005, The Utah Division of Substance Abuse and Mental Health published the Consumer Satisfaction Survey Report. The purpose of the report is to provide government officials, treatment centers, consumers, and their family members with data on satisfaction with services. The findings of this report are also used to provide the Federal Government with outcome data for the Mental Health Block Grant.

Instruments

For the past two decades, the national Mental Health Statistics Improvement Program (MHSIP) has worked closely with the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), the National Association for State Mental Health Program Directors Research Institute (NASMHPD / NRI), and with various states to develop national mental health standards. Among the outcomes of this work are the three MHSIP survey instruments used to collect data for this report: The MHSIP 28-Item Adult Consumer Satisfaction Survey, The Youth Services Survey (YSS) completed by youths, and the Youth Services Survey for Families (YSS-F) completed by a parent or guardian. Each survey contains five measured domains. Contact Shawn Peck, Research Analyst for DSAMH (538-4148) for a breakout of each domain:

- General Satisfaction
- Good Service Access
- Quality & Appropriateness/Cultural Sensitivity
- Participation in Treatment Planning
- Positive Service Outcomes

Survey Methods

In FY2004, the local service providers began conducting point-in-time MHSIP surveys rather than reporting data on a quarterly basis to the Division. The survey was administered to consumers of both substance abuse and mental health services. The surveys are completed in the office by anyone who comes in for a service, regardless of the duration they have been in treatment.

Beginning FY2005, the YSS and YSS-F surveys were conducted in this same manner. As a result, comparison with 2004 YSS and YSS-F data is not valid.

Following are the total number of surveys that were completed:

	FY2004	FY2005
MHSIP:	3,568	3,473
YSS:	NA	675
YSS-F:	NA	536

Computation of Scores

The following methods, which are similar to those used by the federal government (http://www.mhsip.org/reportcard), were used to calculate scores for the scales and graphs in this report:

1. "Not applicable" values are considered null and surveys with more than 1/3 of the items in the scale missing are excluded from the results of that scale.
2. For each respondent, for each scale, calculate an average (mean) score for all items in the scale.
3. For each scale, count the number of mean scores (Step 2) that are more than 3.5. These scores, when rounded, represent "Agree" or "Strongly Agree" responses.
4. For each scale, divide the results of Step 3 by the number (count) of Step 2 scores computed to obtain a percent of favorable responses.

Results

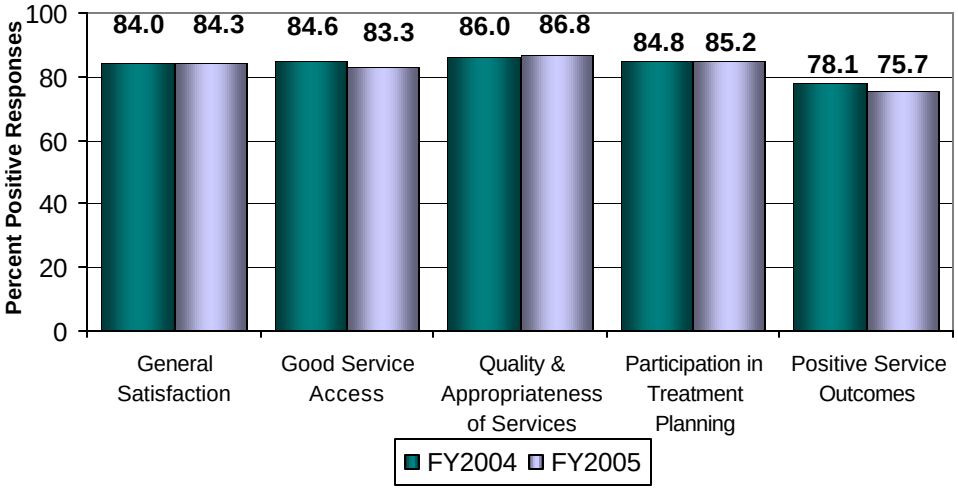
The percentage of individuals reporting positive responses for all scales in the MHSIP survey did not significantly differ from FY2004 to FY2005. In both years, more than 75% reported positive responses in all scales.

The YSS survey, completed by youth, shows a majority of positive responses. The Cultural Sensitivity scale had the highest percentage of positive responses at about 73%.

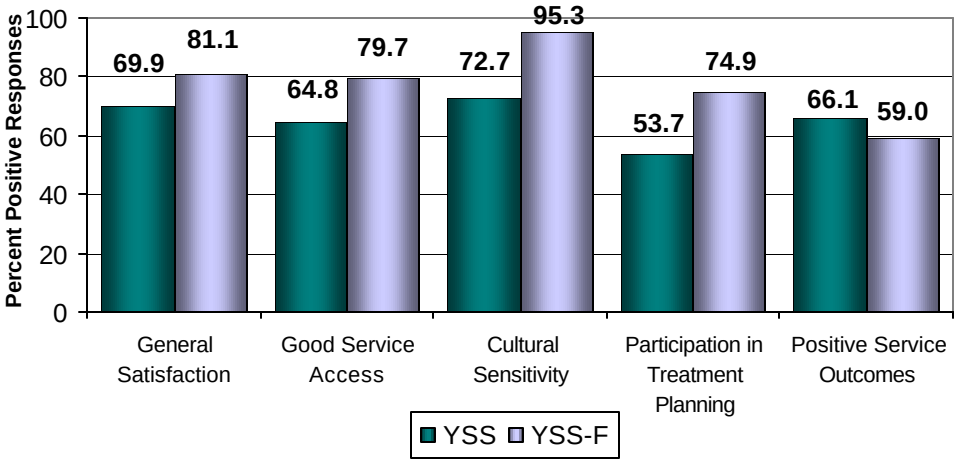
In four of the domains, the YSS-F survey, completed by a parent or guardian, shows a higher rate of positive responses than the survey completed by youth. A higher percentage of youth reported Positive Service Outcomes than did the parents or guardians. Over 95% of the respondents in the YSS-F reported positive responses in the Cultural Sensitivity domain.

The first graph below shows a summary of the MHSIP survey for fiscal year 2004 and 2005. The second graph depicts the scored from the fiscal year 2005 YSS and YSS-F surveys.

Mental Health Statistics Improvement Program (MHSIP),
Adult Consumer Satisfaction Survey
Adults in Substance Abuse or Mental Health Treatment



Youth Services Survey (YSS completed by Youth) and Youth Services Survey (YSS-F completed by Parent orGuardian)
Fiscal Year 2005



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STATE HOSPITAL

Dear Friends, Consumers, Families, and Community Members,

Once again, the Utah State Hospital has reached a level of excellence that makes us a nationally recognized facility. This 2005 Annual Report depicts our success in service delivery. These achievements reinforce our commitment to the USH Mission "To Provide Excellent Inpatient Psychiatric Care". As we continue progressing towards a model of Recovery, our patients gain a sense of Hope for a better future.

We strive to be a valued healthcare provider in the continuum of mental health services for the State of Utah. We are dedicated to the advancement of technology, evidence based practices and research. We are nationally recognized as a leader in development of an electronic record. We are proud of our staff who are loyal to the patients and the hospital. This is what builds the important trust and relationships needed for patients to move forward in their recovery. We appreciate the support of family members in the care of their loved ones. We feel the consumers and family relationships are a vital part of recovery.

We are grateful for the involvement of other state agencies and stakeholders who support our efforts and work in a collaborative effort to address the needs of our patients. Thanks to all who have made this another successful year. We will continue to advance as a quality hospital as we strive together for excellence.

Please read our annual report to learn more about who we are as the State Hospital in Utah and what we are as the State Hospital in Utah and what we have accomplished as well as our focus toward the future.

Sincerely,

Dallas L. Earnshaw

Dallas Earnshaw
Superintendent
Utah State Hospital

Utah State Hospital is fully accredited by Joint Commission of Accreditation for Hospitals Association and also fully accredited by the American Psychological Association.

Utah State Hospital Highlights of the Year

Accreditation & Licensing

- Full JCAHO accreditation for 3 years
- Full APA accreditation for 5 years
- Full Medical CME re-accreditation for 4 years
- Department of Health licensure for 384 beds
- Active membership in Western Psychiatric State Hospital Association

Treatment

- Recognized by national experts for use of the Recovery Model for Mental Health
- Recognized nationally for development of the electronic chart
- Developed and implemented a Wellness Champs Program to promote exercise and nutrition with patients and staff
- Improved delivery of services by development of highly individualized Pediatric Treatment Tracks
- Continued to use less restraint and seclusion with patients than the national average
- Developed and implemented defusing process for unit staff
- Continued to develop individualized behavioral support plans to assist the most recalcitrant patients achieve their goals
- Developed a Fall Risk Assessment and Pain Assessment for every patient on admission and at regular intervals
- 136 patients were involved in off unit industrial work assignments
- 114 patients were involved in on unit industrial work assignments

Research

- Development of specific Brief Psychiatric Rating Scale (BPRS) cut scores which statistically/empirically differentiate typical scores for Utah State Hospital patients from community mental health center outpatients and from individuals without serious and persistent mental illness in the community - these scores assist hospital staff in making disposition decisions by comparing a given patient's functioning with that of other patients at the hospital and with those who are in community mental health center treatment
- Development of a reliable change index for the BPRS
- Generation of specific subscales of the BPRS that reflect various aspects of patients' functioning - this provides a method of feedback to treatment teams on an individual patient's progress or needs
- Incorporated the cut scores, the reliable change index and the subscales into the electronic medical record so that treatment teams have immediate access to this data, as well as historical data on these measures to gauge patient progress.

Publication of Articles in Professional Journals

- Outcome Measures with Psychiatric Inpatients Diagnosed as Severely and Persistently Mentally Ill: A Guide for Instrument Selection. Burlingame, G.M., Dunn, T.W., Chen, S, Lehman, A, Axman, R., Earnshaw, D., Rees, F.
- Implementing a Multi-source Outcome \ Assessment Protocol in a State Psychiatric Hospital: A Case Study from the Public Sector. Earnshaw, D., Rees, F., Dunn, T.W., Burlingame, G.M., Chen, S.
- Sensitivity to Change of the Brief Psychiatric Rating Scale—Extended (BPRS-E): An Item and Subscale Analysis. Burlingame, G.M., Seaman, S., Johnson, J.E., Whipple, J., Richardson, E., Chen S., Earnshaw, D.,

Spencer, R., Lehman, A.
- Psycho-educational Group Treatment for the Severely and Persistently Mentally Ill: How Much Leader Training is Necessary to Realize Patient Improvement? Burlingame, G.M., Earnshaw, D., Ridge, N.W., Matsuno, J., Bulkley, C., Lee, J., Hwang, A.D.
- Case Study: Change of Toothpaste Leads to Better Oral Hygiene among Patients. Foster, J. K. Infection Control Today, June 2005.

State Employee of the Year

- Utah State Outstanding Employee of the Year- Kathy Ferriera

"Kathy Ferreira is the State of Utah 2005 Outstanding State Employee! Kathy was honored by Lt. Governor Gary Herbert in July 2005. Kathy is a Psychiatric Technician and Unit Clerk at the Utah State Hospital. The award nomination described Kathy, "She sees obstacles as a challenge, rather than an excuse. She is a self-starter who applies constructive intellect and high energy to begin a task. One such accomplishment was creation of a schedule for the SouthWest Unit at the Utah State Hospital. This was a challenging assignment due to the number of groups outside and inside the unit. She not only created a schedule, she created a computerized schedule that automatically changes individual schedules, auxillary programs and the unit master schedule when a change occurs in any of them. With no formalized computer training, this is truly extraordinary.

Congratulations Kathy! The Department of Human Services is honored to have the 2005 Outstanding State Employee in our department."

(The Human Touch, September 2005)

Emergency Preparedness

- A member of the National Disaster Medical System providing 15 beds for use in case of emergency somewhere in the country
- Purchased additional emergency equipment as part of the hospital's disaster preparedness plan

Facilities

- Received Construction Monies to replace the aged Warehouse and main sewer line
- Received design monies for replacement of the Slate Canyon Water line

Forensic

- Re-opened 26 bed Forensic Unit to meet the needs of the community
- Improved communication with the prison, district judges, designated examiners, and others through training, meetings and persistence in providing an excellent service

Utah State Hospital Programs

Adult Services

Adult services is comprised of five adult psychiatric treatment units. Each unit provides care for 30 men and women and utilizes various treatment modalities to clinically stabilize the patients while teaching the necessary life skills to maintain a quality of life in the community.

Geriatric Unit

The Geriatric Unit serves 30 patients. It is the goal of this program to offer excellent mental health treatment to patients 60 and older who require special understanding, care, and attention. The treatment approach is highly individualized in recognition of the fact that the aged are not all alike.

Pediatric Services

The Children's Unit serves 22 boys and girls ages 6 to 13 years. These children have experienced mental, emotional, and behavioral problems such as post traumatic stress disorder, pervasive development disorder, bipolar disorder, attention deficit disorder, psychosis and major depression.

The Adolescent Unit serves 50 youth ages 13 to 18 years. Often admittance to this program is considered a "new beginning" for the teenager.

The individualized treatment approach meets the needs of the child and utilizes a broad spectrum of therapeutic modalities. Therapies include individual, group, family, play, and therapeutic milieu. Specialized services to deal with abuse, anger management, emotion management, and recreational therapy are used. Participation in a wide variety of activities helps to gain experience in needed social skills, self esteem, and impulse control.

Family involvement is important in the development and progress of the child's treatment program. The Hospital involves families by conducting the Pediatric Services Family Program which includes family therapy, family support and advocacy. Home visitation is an integral part of the treatment process and regular family visits are encouraged.

Forensic Unit

The Forensic Mental Health Facility is a maximum security unit and serves 100 male and female patients. The majority of these patients are ordered to the Hospital by a District Court under the Utah State Criminal Code. Patients are evaluated while at the Hospital to determine competency and are referred back to the court for sentencing when considered competent. The court may set a trial date or refer the patient to the Utah State Prison or back to the Hospital for further evaluation and /or treatment.

Patient input is encouraged at all levels of treatment which teaches individual responsibility and accountability. It is the goal of the Forensic Unit to help prepare each patient to reenter society as a productive, contributing member.

Specialized Treatments

Therapeutic Recreation Services

Therapeutic Recreation is a professional service which uses recreation as a treatment and education modality to help people with disabilities and other limitations exercise their right to a lifestyle that focuses on functional independence, health, and well-being in a clinical setting. Utah State Hospital offers therapeutic recreation services to all patients on all units of the hospital. These services are goal oriented and directed toward the treatment of specific physical, emotional, mental and social behaviors.

Therapeutic Recreation activities may be held on units, on grounds, and in the community. Activity involvement may include: social and cultural skills, physical skills, intellectual skills, craft skills, outdoor/camping skills, and leisure education skills. Utah State Hospital's ample campus offers opportunities for recreational activities without leaving Hospital grounds. Many patients enjoy visiting the swimming pool where water aerobics and games are a favorite activity. A full-size gymnasium offers varied sports activities and the weight/exercise room is available for a more regimented workout.

A sports court is also located on campus. Team sports are a great way to get some exercise and enjoy some social interaction as well.

The Castle Park and Pavilion is a unique area which includes a barbecue area, rest rooms, volleyball court, and a fish pond (complete with fish). This area is a beautiful setting for group activities and offers individuals a place to relax and enjoy nature.

Occupational Therapy

Occupational therapy treatment is focused toward maintaining and improving skills in personal management of activities of daily living and community living is the focus of treatment. Purposeful activities are utilized to give meaning to every day routines. The activities may address areas of need in regards to reality orientation, cognition, work, and social skills. A sampling of the skills would be the ability to work cooperatively with others, attention to task, ability to complete routine daily tasks, ability to take responsibility for own living area, personal hygiene and grooming, and work duties.

Vocational Rehabilitation

The Vocational Rehabilitation Department offers services that will assist the patient with successful transition into the community.

Industrial Therapy, Supported Job-Base Training and Supported Employment are programs designed as training grounds for individuals to learn, work, grow in confidence, and live as independently as possible in the least restrictive environment.

Sunrise Program

The Sunrise Program is an intensive day treatment program offered at the Utah State Hospital to patients with a dual diagnosis (mental illness/substance abuse). This program is for patients who are hospitalized and are willing to attend the six week program. Patients are referred to the program by their treatment team.

The treatment philosophy at the Sunrise Program is to involve the patient as an active partner in the comprehensive treatment of their dual diagnosis. The patients are educated and taught how to gain insight regarding their mental illness and substance/chemical dependency issues. They are assisted in acquiring skills for recovery and relapse prevention, thus reducing the number of hospitalizations. The patients are taught to develop new and healthy support systems in their recovery program.

Alcoholic Anonymous meetings are held weekly so that patients may attend.

Excel House

Excel House is a unique program modeled after Fountain House, an international clubhouse program in New York City, which focuses on community rehabilitation for severely disabled psychiatric patients.

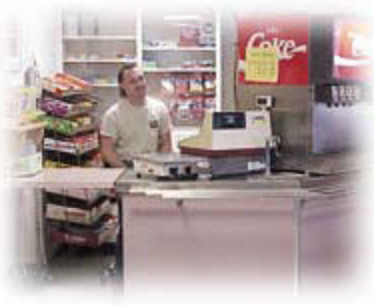
Excel members help to run the clubhouse program and maintain the residence itself. Members are asked to carry out various duties while they learn valuable skills and work at developing problem solving, organizing and follow-through skills.

The members are expected to use their talents and develop responsibility. The Excel Program provides members with a link between clinical and community environments, maintaining a connection with an individual's home community within a hospital setting.

Other Services

The *Patient Library* helps to keep patients current on what is happening in the world around them. Popular books, current music, monthly periodicals, and a variety of computer software are available for those patients wishing to make use of them.

The *Hyde and Rampton Cafeterias* serve nutritious and appetizing meals. Licensed dietitians plan so the meals meet federal guidelines while also meeting the needs of those requiring special diets. The Canteen, located in the Heninger Building, is open daily for a sweet treat or a place to visit with family and friends.



The *Beauty Shop* offers the latest in hair fashion and encourages patients to develop good hygiene habits which result in a better self image. The *Clothing Center*, operated by volunteers, offers patients the chance to select needed clothing from donated items as well as new items.

Chaplain Services

Chaplain Services are intended to help meet the spiritual needs of the residents. Holistic health for our patients necessitates provision for their spiritual recovery as well as healing from physical and mental illnesses. Residents are encouraged to grow spiritually and are assisted in their efforts to worship according to their personal preference. Professional pastoral counseling is provided by the Chaplain or by a pastor of a resident's denomination as requested.

Legal Services

The Hospital Legal Services Department is the liaison between the Hospital and the Attorney General's Office, the courts, and other legal providers. Legal Services is a resource for patients, family, and staff members who have questions regarding legal issues pertinent to Hospital procedure, patient care, and court functions. They also coordinate court schedules which include adult and juvenile mental health hearings, guilty and mentally ill review hearings, and medication hearings. Patients have access to a hospital contracted attorney to assist with legal matters.

Clinics

Dental, Podiatry, Optometry, Neurology, and Audiology services are provided for all patients on hospital grounds. Other medical treatments are obtained for patients through outside providers.

Physical Therapy

Physical Therapy provides treatment for all patient care units and offers a variety of modalities including whirlpool, hydro collator packs, paraffin bath, ultrasound, and electrical stimulation plus various pieces of exercise equipment such as exercycles, Health Rider, Nordic Track, stair steps and assorted weights and apparatus.

Schools

Mountain Brook Elementary School is an elementary school program for children 12 years and younger. East Wood High School is a secondary school for youth between the ages of 13 and 18. Together, these two programs serve approximately 75 school-age students who are residents of the Utah State Hospital.

Provo City School District is the agent for the Utah State Board of Education for overseeing the public school programs operated at the Hospital. The teachers, specialists, administrators and others of East Wood High and Mountain Brook are employees of Provo City School District. It also provides Adult Education programs for adult patients who want to complete their GED.

Volunteer Services

Active volunteer involvement accomplishes a dual role at Utah State Hospital. First, it helps our patients to feel accepted by the community and helps them to relate socially. Secondly, community involvement is a teaching experience to help educate the community about mental illness and the programs offered at USH. Volunteers help in a variety of areas. They are involved with occupational, recreational, and physical therapy. They keep the coffee shop open during weekend hours and many church and community groups sponsor patient activities.

Volunteers are a valuable resource to the Hospital and their involvement is always encouraged and welcome. There are many opportunities for individuals, groups, students, Eagle Scouts, etc. to volunteer at the hospital especially during the summer months.

NAMI

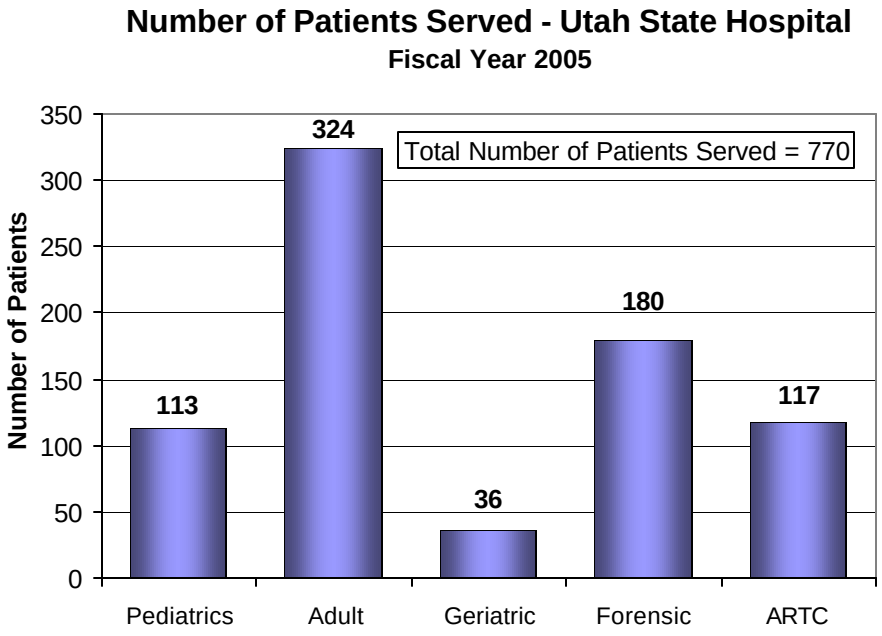
Utah State Hospital works closely with the National Alliance for the Mentally Ill Utah Chapter including active participation in the NAMI provider program and the Bridges program. Consumers and families meet twice monthly at the hospital as a support group.

The Cottage

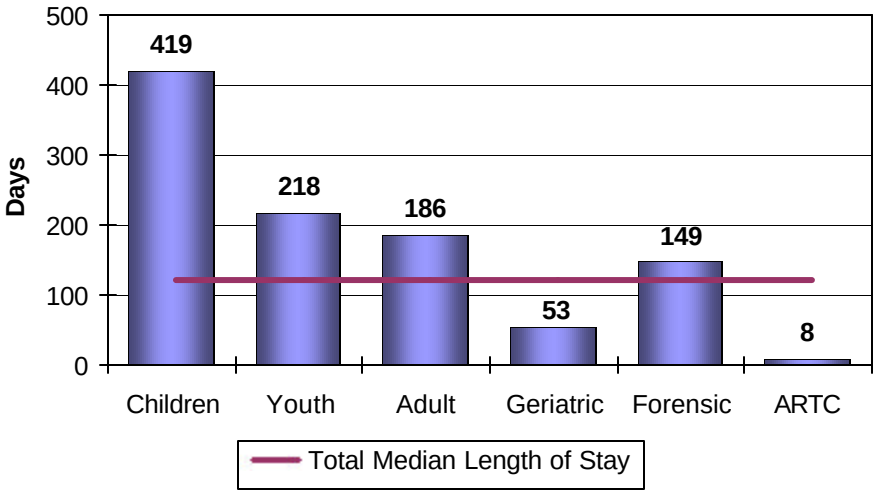
A small older home on the grounds of the hospital has been converted to a home like environment where patients' family members from a distance may come to stay while visiting their family member. There is a nominal fee for their overnight stay.

College/University Affiliations

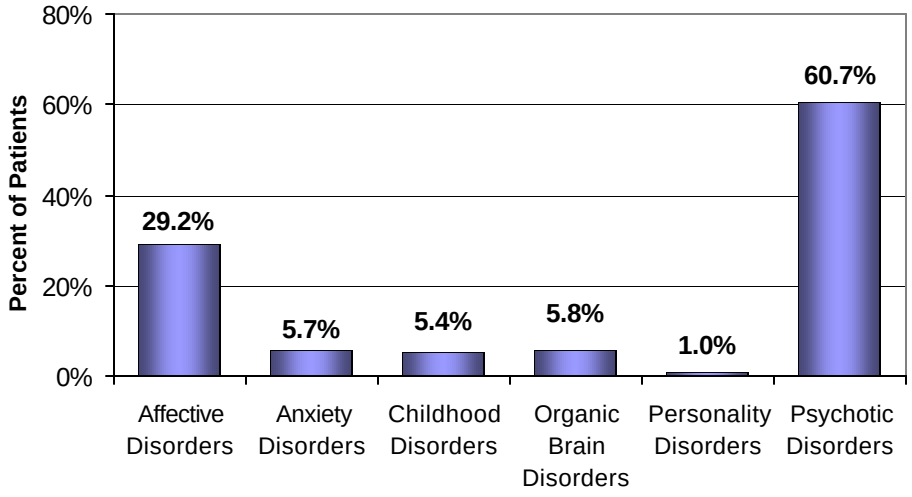
Utah State Hospital provides educational experiences for Nursing, Social Work, Recreational Therapy, and Psychology students as well as Medical School residents from Brigham Young University, University of Utah, Weber State University, Utah Valley State College, College of Eastern Utah, and Salt Lake Community College.



Median Length of Stay in Days - Utah State Hospital
Fisal Year 2005

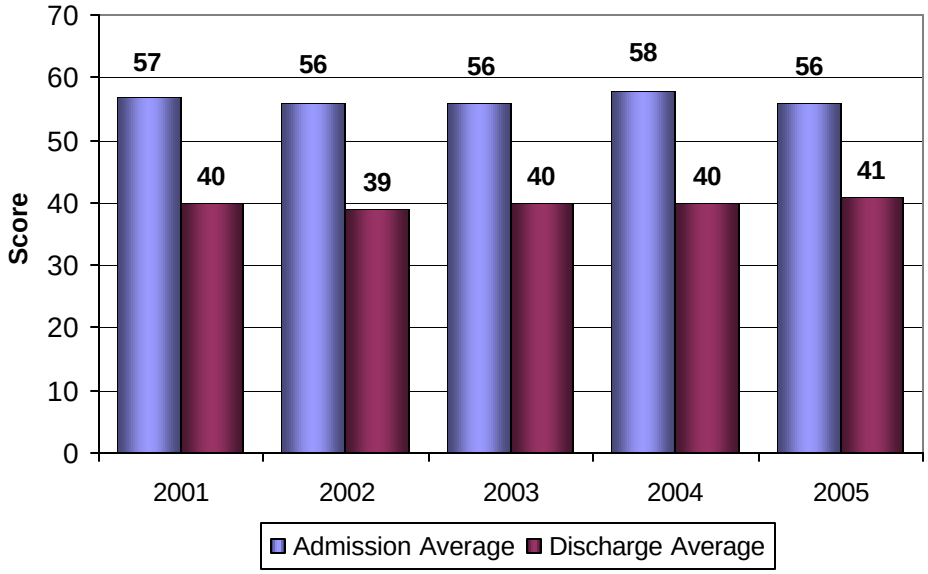


Percent of Patients with Major Psychotic Diagnosis* - Utah State Hospital
Fiscal Year 2005

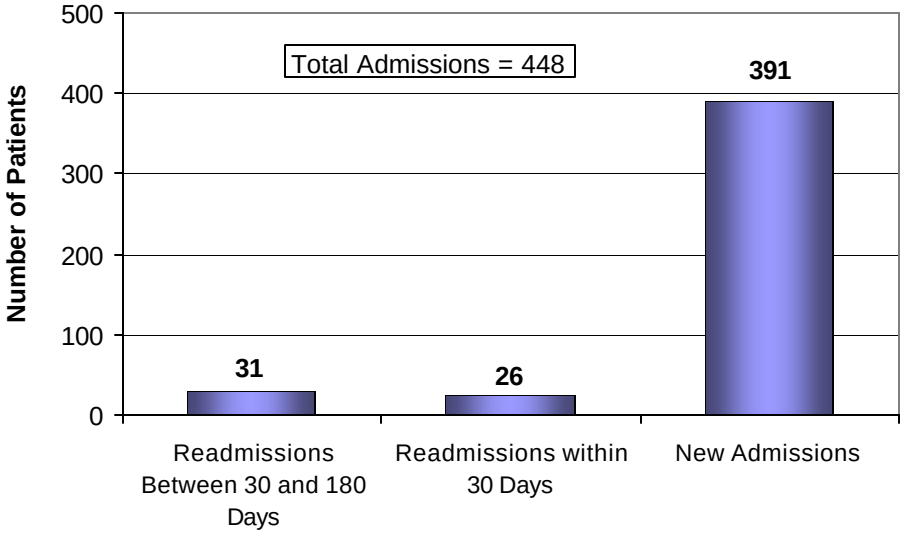


*Patients can have more than one diagnosis

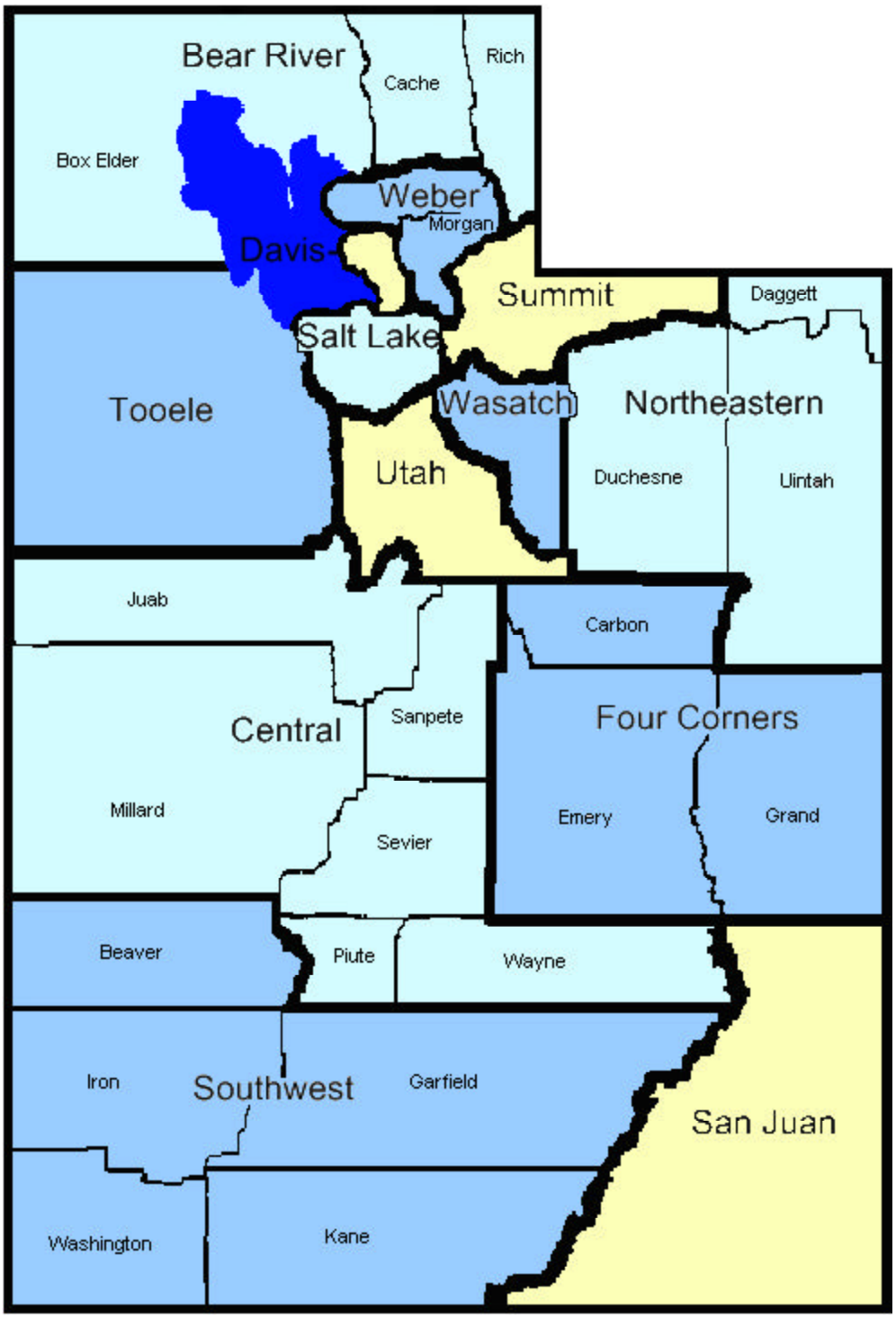
Average Symptom Levels of Patients Discharged Compared to Their Admission Symptom Levels as Measured by the Brief Psychiatric Scale - Utah State Hospital



Readmissions at the Utah State Hospital
Fiscal Year 2005



Local Authorities and Treatment Centers



Bear River Health Department
(Box Elder, Cache, and Rich Counties)

Bear River Substance Abuse provides effective alcohol and drug prevention services to residents in Utah's three northernmost counties- Cache, Rich and Box Elder. Services are provided in two offices:

Programs provided by Bear River Substance Abuse include:

Adult Outpatient Services
Assessments
Drug Court
Intensive Outpatient Treatment
Spanish Outpatient Services
Women's Outpatient Services
Youth Outpatient Services
Substance Abuse Prevention

Bear River Mental Health
(Box Elder, Cache, and Rich Counties)

Bear River Mental Health, Inc. is the provider of services for the Local Mental Health Authorities of Box Elder, Cache, and Rich Counties. The full continuum of state-required services are provided for the three-county region for both children and adults. Services provided include:

- Inpatient
- Residential
- Outpatient
- 24-hour crisis
- Psychotropic medication management
- Psychosocial rehabilitation
- Case management
- Consultation and education
- Forensic services

Bear River Mental Health Services focuses on a team approach that is community-based. After establishing the initial diagnosis, based on a professional assessment, a treatment plan is developed that takes into account the total mental health needs of the individual and/or family, in the case of children and adolescents. A mental health professional serves as the treatment coordinator and primary therapist for all clients. When necessary, medical services are coordinated with the provision of other services. Additionally, case management and skill development services are also available as needed. Individual, group, and family therapy are modalities that might be prescribed as well as part of the treatment plan.

All services are delivered in order to meet the objectives established to treat the symptoms of the diagnosed mental disorder(s). It is the philosophy of Bear River Mental Health to maintain the client in the community in the least restrictive setting possible, with the level of service needed to accomplish that end.

The primary funding source for Bear River Mental Health is Medicaid, with the majority of state and local county match dollars being used to meet the Medicaid match requirement. The majority of the clients served are now Medicaid eligible. However, Bear River Mental Health's Local Authority Oversight Committee and Board of Directors prioritized that services would continue to be provided at the level possible to the seriously and persistently mentally ill adult population and the severely emotionally disturbed child and adolescent population with any remaining state and county dollars. All other service recipients must have other means available to pay for services received. This has resulted in a large number of citizens being referred to other resources in the community or being denied services. This has created a gap in the treatment availability continuum in the three-county area. In particular, those individuals who do not qualify for Medicaid due to family assets or family income level, although they may be minimal, are no longer able to receive the professional mental health care they have historically had available to them.

It is projected that in the next few years, only Medicaid eligible consumers will be able to be served by Bear River Mental Health without an increase in state and county funds, as the population continues to grow, creating an even larger gap in service availability.

Central Utah Counseling Center

(Juab, Millard, Piute, Sanpete, Sevier, and Wayne Counties)

Central Utah Counseling Center provides both mental health and substance abuse services to individuals and families living in the six-county area located in the center of the state. The counties served by Central Utah Counseling Center include:

- Juab County
- Sanpete County
- Millard County
- Sevier County
- Piute County
- Wayne County

The following services are available and can be provided in either Spanish or English:

- Evaluation
- Individual and Group Therapy
- Family Therapy
- Medication Management
- Individual Skills Training and Development
- Psychological Rehabilitation Services, or Day Treatment
- Drug and Alcohol Services

In addition, we also provide substance abuse prevention services primarily in the schools.

Davis Behavioral Health
(Davis County)

Davis Behavioral Health is a comprehensive and integrated system of mental health and substance abuse services for adults, adolescents and children. Davis Behavioral Health is the contract provider for Davis County.

Individuals with a serious mental illness or an addictive disease are the primary population served. Serious mental illness includes schizophrenia, bipolar disorders, and obsessive-compulsive disorders.

Davis Behavioral Health also provides mental health service for all individuals with Medicaid benefits or eligibility for Medicaid. Davis Behavioral Health's wide range of programs and treatment options allows for individualized, appropriate care for individuals and their families.

Our Mission

Our Mission is to provide comprehensive, quality behavioral health services to individuals, families and our community through: Effective Clinical Practice with Evidence-based Outcomes provided in a Fiscally Responsible manner to ensure Client/Family, Community and Staff Satisfaction.

Our Vision

We are committed to excellence in community-based behavioral health treatment, progressive, vital and continually responsive to the needs of the community, and advocates for the behavioral health needs of our clients.

2005 Review

The most substantial change during 2005 was a reduction in the number of non-Medicaid mental health clients served. This change was a result of anticipated changes to Medicaid funding which impacts non-Medicaid clients.

Adult Mental Health

Adult mental health programs have been re-aligned to a prioritization of services which are medically necessary. This has resulted in a reduction of the number of services in our day-treatment program. Our residential facility also saw some reduction in services due to the difficulty of nurse recruitment.

Children and Youth

The Davis Behavioral Health Children and Youth services have been relatively consistent throughout the year. One major exception is the completion of the Juvenile Drug Court Grant received by Davis School District in conjunction with Davis Behavioral Health and the Second District Juvenile Court. During the evaluation it was determined that the Juvenile Drug Court was so successful that a decision was made to utilize existing resources from the three agencies involved to keep it functioning, even on a smaller level.

This year, Davis Children and Youth Team has increased utilization of off-panel day treatment and residential services. The youth seem to be struggling with more severity than noted in years past. One of the major challenges has been to provide services to the developmentally delayed/mentally ill children and youth. There is a plan to improve services to this dually diagnosed population during the coming year.

Davis Behavioral Health has been able to provide more services to clients, one to five years of age. This has been a pleasant increase of services and one which is believed will be preventative. Davis Behavioral Health has also contracted with a family advocacy agency to provide orientation and training through a monthly support group as well as providing some peer parenting/skill development services. All family advocacy staff are appropriately supervised and have been certified by the Division as Targeted Case

Managers.

During this past year, we have operated as a training site, completed training in Functional Family Therapy, and received training in Motivational Interviewing, Trauma Training, Teaching Family Model and Social Solutions.

Substance Abuse Prevention

Davis Behavioral Health has been able to sustain all of its SICA programs through collaboration with other area agencies. Those programs are:

- Across Ages mentoring program continues to gain momentum and is partnering with Utah State University
- Reconnecting Youth continues by providing two classes at Davis School Districts two most at risk Junior High Schools
- Functional Family Therapy trained therapists continue to provide this evidence based practice that has seen significant results
- Strengthening Families Program (10-14) continues to be implemented as a collaborative effort between Davis Behavioral Health and the Davis School District

Further, Davis Behavioral Health continues to find tremendous success with its parenting programs. Parenting classes are being offered three times per week at an average of 45 attendees per class.

Substance Abuse Treatment

Davis Behavioral Health utilizes treatment interventions based on specific evidence-based approaches, techniques and strategies that provide treatment goals and objectives specific to the individual client. These components include Motivational Interviewing, Behavioral Contracting, Life Skills Training, Case Management, Relapse Prevention, 12-Step Facilitation, and Cognitive Behavioral Therapy.

Davis Behavioral Health has made program changes in order to provide gender specific treatment and enhanced services for pregnant women that include comprehensive residential and outpatient treatment, vocational and educational training, housing, prenatal follow-up and case management.

All Davis Behavioral Health addiction services programs are dual diagnosis capable with a primary focus on the treatment of substance related disorders, and are also capable of treating clients with diagnosed co-occurring mental health problems.

Four Corners Community Behavioral Health
(Carbon, Emery, and Grand Counties)

Sustaining Collboration & Innovation with Shrinking Resources

Like much of rural Utah, Carbon, Emery and Grand Counties continue to lose population. As a result there has been a decrease in state general fund dollars to serve individuals with mental health and substance abuse problems. Although access to services for all but those with the most severe problems has been sharply limited, Four Corners Community Behavioral Health (FCCBH) continues to develop innovative programs to make every service dollar count. Four Corners has just launched a new three-year strategic plan which refines the agency's focus on quality services.

FCCBH has taken the lead in developing drug court programs in all three counties. Collaborative efforts with law enforcement, the courts and the Division of Child and Family Services (DCFS) have paid off and drug courts are now operating in all three counties.

- Using federal COPS and earmarked federal DOJ funds a full adult felony drug court is now operating in Carbon County alongside the less comprehensive dependency drug court
- Emery County's felony drug court continues to show impressive results with high completion and low recidiviism rates
- Grand County has received a three year federal DOJ grant to start a model adult felony drug court. This will join the less comprehen sive dependency court already operating

The Program for Assertive Community Treatment (P/ACT) service for Carbon and Emery residents has continued in spite of the end of the state's three-year funding for the start of this model program. The program's clients have compiled impressive decreases in hospital and jail time and have made great gains in getting and keeping stable housing.

Wrap-around services and intensive case management to SED children and their families has been sustained beyond the end of the federal Frontier grant as FCCBH has made these effective services available to Medicaid enrollees and their families. Working to build on family strengths in a collaborative setting has become the core of the system of care for SED children and their families in Carbon, Emery and Grand Counties.

Four Corners has just signed a contract with the Carbon Medical Association, Inc. to expand mental health services from the Green River Clinic to the clinics in Helper and East Carbon. This contract allows funds from the federally qualified health centers to augment the mental health services for those without Medicaid.

Heber Valley Counseling
(Wasatch County)

Heber Valley Counseling was established in July of 2003 by merging the mental health services previously offered by inter-local agreement by Wasatch Mental Health of Provo and the Center for Alcohol and Drug Services, run by Wasatch County, into one county operated service. The mission of Heber Valley Counseling is to provide the residents of Wasatch County comprehensive mental health and substance abuse services across their lifespan that are accessible, professional, caring, and of high quality. Furthermore, our goal is to promote a healthy and drug-free community through education and treatment.

Fiscal year 2004 was a year of transition and a rough start for our newly acquired mental health program. Fiscal year 2005 was about getting down to business. After making organizational changes and hiring a new mental health staff and supervisor, we were off and running, increasing our direct service to clients by 210% the year following the re-organization. For the first half of fiscal year 2006, our direct service has increased by 251% over that first year. We have a committed group of mental health professionals working together as a team, finally realizing one of the goals of the merger - to increase services to the residents of Wasatch County.

Mental health services provided by Heber Valley Counseling include:

- Screening and assessment
- Outpatient therapy
- Medication Management
- Case Management
- Day Treatment
- Crisis Services
- Inpatient and residential placement

Substance abuse services have grown at a rate of 3% each year, treating 120 unduplicated clients. This is our fourth year operating a drug court program, which serves up to 20 participants. Our prevention program includes Promise Mentoring Program in conjunction with the Utah State University Extension Service, an annual community education night, "Issues," which tackles issues facing families and children, the Majority Rules program, family life education, and the substance-free graduation party.

Substance abuse services provided by Heber Valley Counseling include:

- Screening and assessment
- Outpatient services including individual, family, and group therapy
- Drug Court
- Detox & Residential Treatment
- Crisis intervention
- Prime For Life DUI Education Program
- Prevention Programs
- Family Life Education Classes

Northeastern Counseling Center
(Daggett, Duchesne, and Uintah Counties)

"Promoting Behavioral Health in the Uintah Basin"

Northeastern Couseling Center provides help to individuals who are having a difficult time with normal activities because of depression, anxiety, excessive fear or other mental illness, and those who have substance abuse problems to overcome their challenges and become healthy, functioning members of society.

Services are provided by professionals and include: 16 Licensed Therapists, Licensed Substance Abuse Counselor, full-time Board Certified Psychiatrist, RN & LPN Nursing Staff, Psychologist, and 10 Certified Case Managers. Services provided include:

Mental Health

- 24-Hour Crisis Intervention
- Screening and Referrals
- Assessments and Evaluation
- Outpatient Services
- Case Management
- Day Treatment
- Medication Management
- Consultation, Education, and Prevention Services
- Transitional Housing

Substance Abuse

- 24-Hour Crisis Intervention
- Screening and Referral for Chemical Dependency Treatment
- Outpatient Services
- Intensive Outpatient Program (IOP)
- DUI Education Classes
- Prevention and Community Education
- EXCEL

We work closely with other community agencies and service providers to develop an individual plan of treatment for those in need of mental health or substance abuse services.

Some services are eligible for private insurance or are pre-paid for Medicaid enrollees. A sliding fee scale is available to the uninsured.

Salt Lake County Division of Substance Abuse
(Salt Lake County)

DORA (The Drug Offender Reform Act)

Senate Bill 1004 – *Drug Offender Reform Act – Pilot Program* passed during the First Special Session of the 2005 Utah Legislature. S.B. 1004 created a three-year pilot study in the courts of the Third Judicial District, located in Salt Lake County. The purpose of the study is to examine the impact of providing substance abuse screening, assessment and treatment for felony offenders charged with violating Utah's Controlled Substances Act (§58-37, Utah Code), from July 1, 2005 through June 30, 2008. Screenings are to be conducted through June 30, 2007; assessments and treatment based on the screenings are to be conducted through June 30, 2008, the final date of the study.

S.B. 1004 appropriated $500,000 for the first year of the program as follows: $75,000 to the Commission on Criminal and Juvenile Justice; $315,000 to the Department of Human Services; $10,000 to the Judicial Council and State Court Administrator; and $100,000 to the Department of Corrections. The pilot program is limited to 250 offenders, at a total cost of $1,417,400. State agencies involved in the pilot study will request the balance of $914,400 during the Utah Legislature's 2006 General Session.

The vision for the Drug Offender Reform Act is to improve Utah's response to offenders with drug addictions. We envision this being accomplished in several ways. First, drug screening and assessment occur prior to sentencing, which provides the judge with specific information regarding the offender's substance abuse treatment and supervision needs. This facilitates more appropriate placement of offenders with a drug addiction. Second, treatment and supervision are adequately funded to ensure offenders requiring treatment are able to access treatment resources immediately after sentencing. Finally, coordination occurs between the treatment provider and the agency responsible for supervising the offender. By keeping each other informed of the offender's progress, both in treatment and on supervision, a more comprehensive array of services and consequences can be leveled at the offender, thus attaining better individual outcomes.

Salt Lake County's Alternatives to Incarceration Initiative

Salt Lake County is trying a new approach to deal with the substance abusing criminal justice population by providing alternatives for the courts to incarceration in the SLCo Adult Detention Center (ADC). Three major programs of this initiative are: CORA (County Offender Reform Act) which provides for an increase in assessment driven, community-based treatment slots; a mental health services diversion program; and, a day reporting center to provide supervision and other supportive services to offenders that have been released from the ADC.

Substance Abuse Treatment – County Offender Reform Act (CORA)

Increased availability of substance abuse treatment allows offenders to be removed from jail or diverted from jail and to be safely supervised and treated in the community. A $400,000 mid-year budget adjustment (July 2005 through December 2005) was appropriated by the Salt Lake County Council to the county Division of Substance Abuse Services for the first phase of this program. The second phase with an increase of $700,000 (total of $1.1 million for twelve months) will be available for calendar year 2006.

Phase one accomplishments are:

- 222 offenders (CORA clients) have been removed from jail or diverted from jail
    - 54% of CORA clients are female
    - Methamphetamine is the drug of choice for 58% of female CORA clients and 32% of male CORA clients
- A substance abuse assessor is located in the jail and is providing on-site assessments, facilitating releases from jail to treatment
- DSAS contracts with the SLCo Sheriff to provide security for the substance abuse assessor who is located within the jail. This allows for greater access to substance abusing prisoners and minimizes operational changes for the ADC staff
- A West Jordan District Court Pilot Project identifies offenders who can be diverted from jail into substance abuse treatment, performs substance abuse assessments, and provides recommendations to judges prior to sentencing

Phase two is expected to accomplish the following:

- 400 offenders (CORA clients) will be removed from jail or diverted from jail
- An additional substance abuse assessor will be located within the jail to increase the reach into the jail population
- Security services provided by contract from the sheriff will continue
- The West Jordan District Court Pilot Project will be expanded
- A substance abuse assessor will be located in the Day Reporting Center for clients who are released from jail or sentenced without an assessment

The project is also seen as a way to increase communication between the criminal justice system and the substance abuse treatment community.

Day Reporting Center

The Day Reporting Center (DRC) is an alternative to incarceration that provides community-based services to offenders in a structured environment, accompanied by community supervision. The Salt Lake County Council appropriated $400,000 to the Division of Criminal Justice Services to start the DRC in 2005 and will continue with a second appropriation for operations in 2006 of $300,000 for a total of $700,000.

- Program elements include: supervision, treatment in community, job development, interim substance abuse services, and life skills training
- Program cycle will be 90-120 days
- Clients will be removed from jail with judicial approval or diverted from jail at sentencing
- The population is estimated to be 100 by the end of the first year and will grow to 250 in year two

The anticipated start date is December 1.

San Juan Counseling
(San Juan County)

San Juan counseling serves the geographical area of San Juan County which is the largest, most sparsely populated and has the highest poverty rates within the State. A large portion of the population of San Juan County is Native American including Navajo and Ute residents. San Juan Counseling provides a full array of quality mental health and substance abuse services to the citizens of this county as well as prevention services.

San Juan Counseling continues to provide prevention services that are mainly focused within the school system in the county. Prevention Dimensions is the Evidence Based prevention system used throughout the county and within all schools. Other prevention techniques within the county include a partnership with the Seventh District Juvenile Court to provide a program called IPASS. This program is geared specifically toward the first-time offender with alcohol or drug use and has been a very successful program. San Juan Counseling has also partnered with the San Juan School District in the provision of general prevention programs within the county. Coordinating with the School District, San Juan Counseling supports safe, drug and alcohol-free graduation activities for graduating high school seniors.

San Juan Counseling is also directly involved in a process called SYNAR checks in which tobacco buys are attempted by an under-age person to test the merchants standards of compliance with the State's laws regarding Tobacco use. Due to these SYNAR checks, San Juan County's percentage of sales of Tobacco products to minors has dropped below the 10% level; beginning at nearly 60% when the program began years ago.

San Juan Counseling provides general substance abuse outpatient counseling to youth and adults and provides an intensive outpatient program to adults also. We also provide DUI classes when requested. San Juan Counseling will begin a planning process to enable a Drug Court program to start in the county within the next 12-18 months.

Southwest Behavioral Health Center
(Beaver, Garfield, Iron, Kane, and Washington Counties)

Southwest Behavioral Health Center provides a full continuum of care to the citizens of Southwest Utah. For several years Southwest Center has increased the capacity to better serve clientele through a comprehensive process of integrated assessment and treatment.

The center has facilitated integration of services by consolidating office space. Both out-patient substance abuse and mental health services are co-located in the same building in all five counties. Southwest Center will soon occupy a new out-patient building in Beaver County (see photo below).

The total needs and strengths of the client are considered when developing comprehensive substance abuse and mental health treatment plans. Multi-discipline treatment teams meet weekly to assure coordination of all treatment services.

Considerable strides have been made during the past year to develop and implement a new computer system. This system provides data elements to meet clinical documentation requirements, state and federal reporting, and billing requirements. Staff are now trained and using many elements of the program. We look forward to the enhancements now under construction to make the program more user-friendly.

Drug Court remains an effective tool to coordinate services with allied agencies and to keep the clients engaged throughout the treatment process. The Washington County Drug Court (serving clients charged with felony drug offenses) received an expansion grant to develop an additional arm to serve adult substance abusing clients under jurisdiction of Juvenile Court. The Washington County Family Court is now operating using federal funding through September, 2006. It is hoped that additional funding can be obtained from the State to continue this court after that date. Residents of Iron County recently met to explore creation of a Drug Court in Cedar City. Interested parties including Judges, the County Attorney, Defense Lawyers, and Southwest Center staff continue to explore funding and implementation options.

Prevention Update

Southwest Center Prevention ended the implementation of the SICA Project as of September 30, 2005. Most prevention programs that SICA funded will be continued utilizing block grant funding and through reorganization of staff responsibilities. Advisory Groups continue in each county despite the loss of SICA funding; these Groups allow County residents to help identify prevention needs at their local level.

PEP continues to be the most effective program at serving youth in our 5 county area; program data continues to show improvement in students GPAs and school attendance. The program has been expanded to Pineview Middle School in Washington County and we hope to be in Milford schools in Beaver County by the end of this school year. Listed below are other programs that will continue within the Five County area:

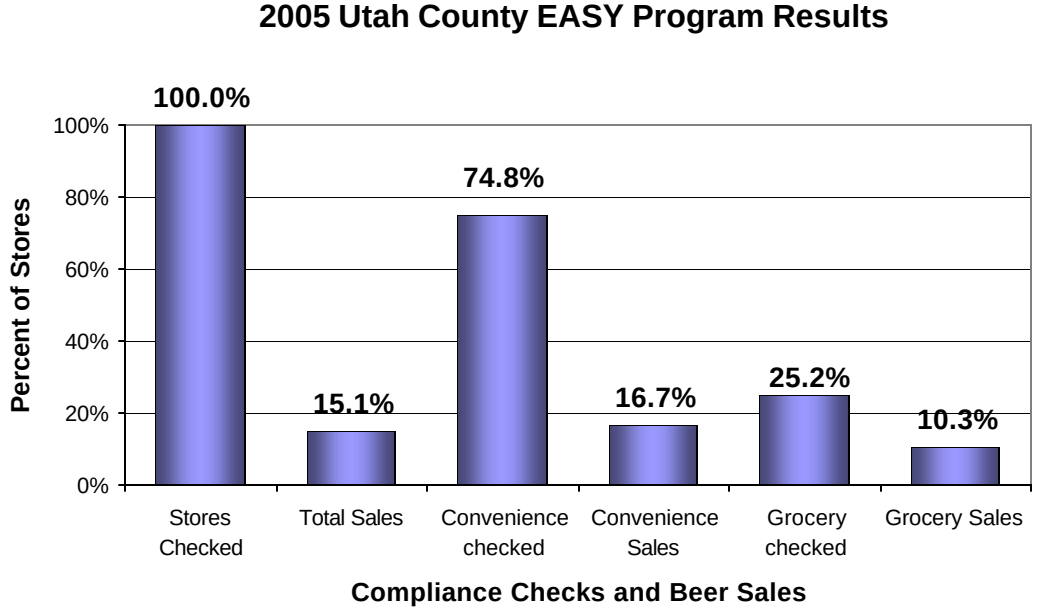
- Project Northland (Kane & Garfield Co.); All Stars (Beaver Co.)
- Youth & Families of Promise –High School (Iron Co.)
- Parents Who Care (Washington).
- Governing Youth Council (formerly known as the Governor's Youth Council)
- Respect
- Free the Horses
- Kid Power
- Personal Power
- Community Family Days, Heaton Ranch, Red Ribbon Month
- Media Literacy
- End Program
- Prime for Life (state mandated DUI education)
- Teen I
- Second Step
- K-12 Training
- Ounce of Prevention (Radio Show)

The Love & Logic program was discontinued in Beaver due to lack of participation, however the Youth and Families of Promise program will continue. Surveys from 1998 to present show a steady decline in substance abuse in our 5 county area. They also show an increase in protective factors and a decrease in risk factors.

Utah County Division of Substance Abuse
(Utah County)

Prevention

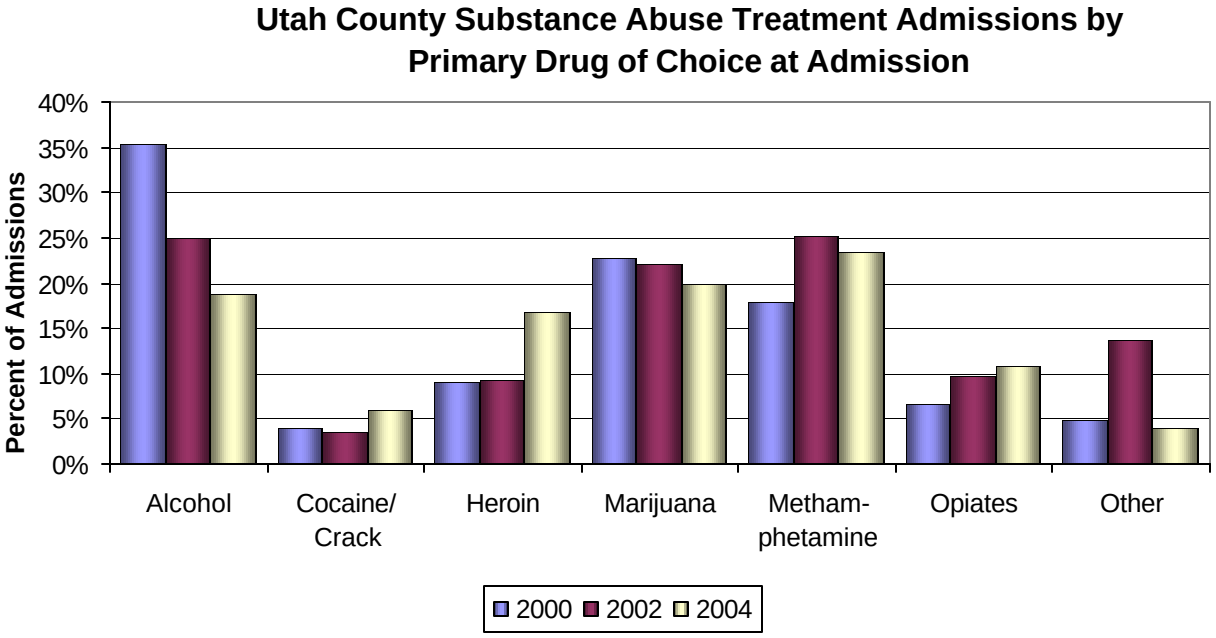
In January 2005, Utah County's prevention staff began implementation of a proven program called "Eliminate Alcohol Sales to Youth", otherwise known as EASY. Modeled on the federal Synar program to reduce tobacco sales to youth, the EASY program is a partnership between local law enforcement, local business and prevention staff. New or amended local ordinances were adopted in all but three cities in the County that allow retail sales of alcohol. By October, 2005, Utah County Division of Substance Abuse (UCDSA) had trained over 3,376 retail sales clerks in the County and conducted nearly 400 compliance checks. Prior to the implementation of the program, the underage sales rate was between 35 and 40%. Presently, the rate is 15.1%. The stated goal of the program is a sales rate below 20%. As far as we know, this is the largest implementation of this type of program in the US to date.



2005 SHARP survey data shows that Utah County continues to have one of the lowest rates of youth substance abuse in the state. Utah County youth report risk factor rates lower than both the state and 7 state regional averages and higher protective factor rates. Drug and alcohol use overall is half or less than the state average, however, the use of inhalants, heroin, and prescription opiates is roughly the same as the rest of the state. These trends will guide prevention activities in Utah County for the next few years.

Treatment

The primary drug of abuse at admission reported by all clients has changed over the past six years. In 2000, alcohol was reported most frequently, but by 2002, it was exceeded by methamphetamine. In 2004, the combination of heroin and prescription opiates such as Oxycontin exceeded meth as the primary drug of choice at admission to treatment.



As the population in Utah County has grown at a rate higher than the rest of the state, funding for treatment has not kept pace. In 2000, UCDSA was able to admit 1755 clients for treatment. In 2004, 1753 clients were admitted. In the same time period, the population of Utah County grew from 368,000 to 437,000 – a rate of increase of nearly 19%. UCDSA now has waiting lists for assessment and referral and for all its treatment programs. In order to adjust to increased demand and stagnant funding growth while providing as much treatment as possible, UCDSA decided not to renew one outpatient treatment contract and bring some of its adult outpatient treatment services in house. The net effect of this change was to increase adult outpatient treatment capacity by 40 clients and to provide culture and language appropriate treatment to the native Spanish speaking population of the county.

Treatment outcomes for UCDSA's programs are positive and substantial, even though the overwhelming majority of clients are court ordered. Nationally, only 7% of substance abuse clients seek treatment on their own. Most are coerced into treatment. Between 70% and 80% of all clients referred to UCDSA are court ordered into involuntary treatment. Even so, treatment is effective. In a study conducted in 2004, re-arrest rates of treatment clients dropped from 10.9 arrests per client prior to treatment to 0.57 arrests per client in the period from 12-18 months after completing treatment. Utah County's felony drug court program is also very effective for one of the most problematic segments of the client population. Eighty-five percent of Utah County Drug Court participants since 1997 graduated from the program. **(Eighty-nine percent** of all Utah County Drug Court graduates since 1997 have had **NO legal charges since completing treatment.)**

Valley Mental Health
(Salt Lake, Summit, and Tooele Counties)

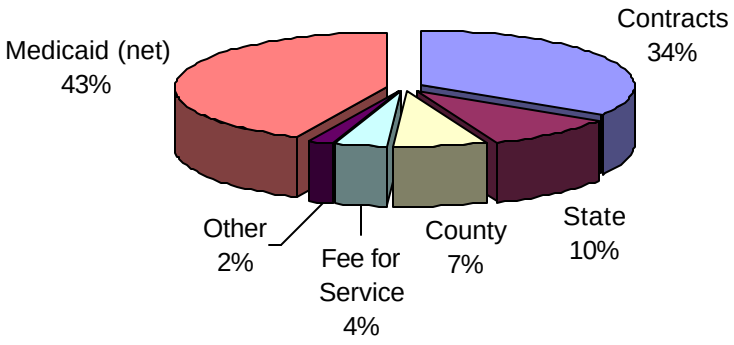
Valley Mental Health (VMH):

- Is a private nonprofit mental health and substance abuse treatment center governed by a volunteer board of directors
- Provides services for children, adolescents, adults and seniors
- Prioritizes services for people who are the most seriously afflicted with mental illness
- Serves 17,800 individuals; 42% are new clients
- Provides services to 5,600 children
- Serves a population where 80% those in treatment live at or below the poverty level
- Offers more than 70 different programs at over 50 locations
- Assists 516 clients with their housing needs, in addition to those clients in residential care
- Employs 1,200 people
- Is the Medicaid service provider
- Maintains a 24-hour crisis line - over 33,000 calls are received each year

Services Include:

- Counseling (group/individual)
- Medication management
- Employment training/skill-building
- Housing opportunities/integration
- Residential/inpatient care
- Day treatment for adults/kids (clinics/ schools)
- Non-traditional services for people who are homeless and mentally ill
- Specialized services for seniors
- Autism services (preschool through 6th grade)
- Forensic services (outpatient/correctional settings)
- Partners with the Salt Lake County Mental Health Court
- Recovery oriented services to provide education, work experiences and skills leading to resiliency

Funding Chart
2005



Wasatch Mental Health
(Utah County)

Under the local authority of the Utah County Commission, Wasatch Mental Health is the provider of mental health services for Utah County. It is the State's oldest community mental health center, and one of the oldest in the nation, dating back to the early 1960's. Wasatch Mental Health is a full-service provider, offering comprehensive treatment and outpatient services to meet the full continuum of State-required services for adults, children, and youth.

These services include inpatient screening and referral, residential treatment and housing services, medication management and nursing services, psychosocial rehabilitation services, case management, forensic services, youth sex offender treatment, school-based services, and 24-hour crisis services and other specialty services. It is the single source provider for Medicaid-insured individuals.

Wasatch Mental Health believes in the efficacy of treatment and the reality of recovery; that all individuals have the capacity to improve and contribute in a meaningful way to society. It operates under the strong conviction that all individuals are entitled to the best and most appropriate service available, and that all people have the right to be treated with dignity, respect, cultural sensitivity, and confidentiality. Services are readily accessible and provided in the least restrictive environment. Results are outcome-based and delivered in best-care practice modalities. Volunteer and community participation contributes significantly to the Center's mission to make a positive difference in the lives of individuals it serves.

The Center serves approximately 5,500 clients annually, of which approximately 70% are seriously and persistently mentally ill adults (SPMI), or seriously emotionally disturbed children (SED). The budget is comprised primarily of Medicaid revenue, but many services are also provided through fee-for-service contracts with allied agencies, and grants. Approximately 76% of expenditures are for professional and support personnel.

Many seriously ill citizens are ineligible for Medicaid, and are without sufficient personal resources to access needed services. To address this volatile unfunded population, this year the Center received an allocation of one-time money from the legislature to pilot a new service, the Wellness Recovery Clinic (WRC). The goals of this new treatment initiative are focused on providing quality and efficient services to a large number of unfunded and disadvantaged clients, on providing evidence-based services in the most effective manner and integrate innovations in service delivery, to work toward community ownership and responsibility, and to be accountable to stakeholders by tracking and documenting treatment outcomes using nationally calibrated measures on an individual and cumulative level.

This year, Wasatch Mental Health completed the initial year of its highly successful Mental Health Court (first for Utah County and second in the State). Following a mental health screening for appropriateness, a mental health court offers a plea-in-abeyance agreement for clients charged with misdemeanors and some non-violent felony offenses. Case managers and a therapist track the treatment progress, and report to the court on a weekly basis. The community support for this new and important service has been outstanding. The first year data demonstrated significant cost-savings in both jail nights and inpatient bed days for clients participating in the program.

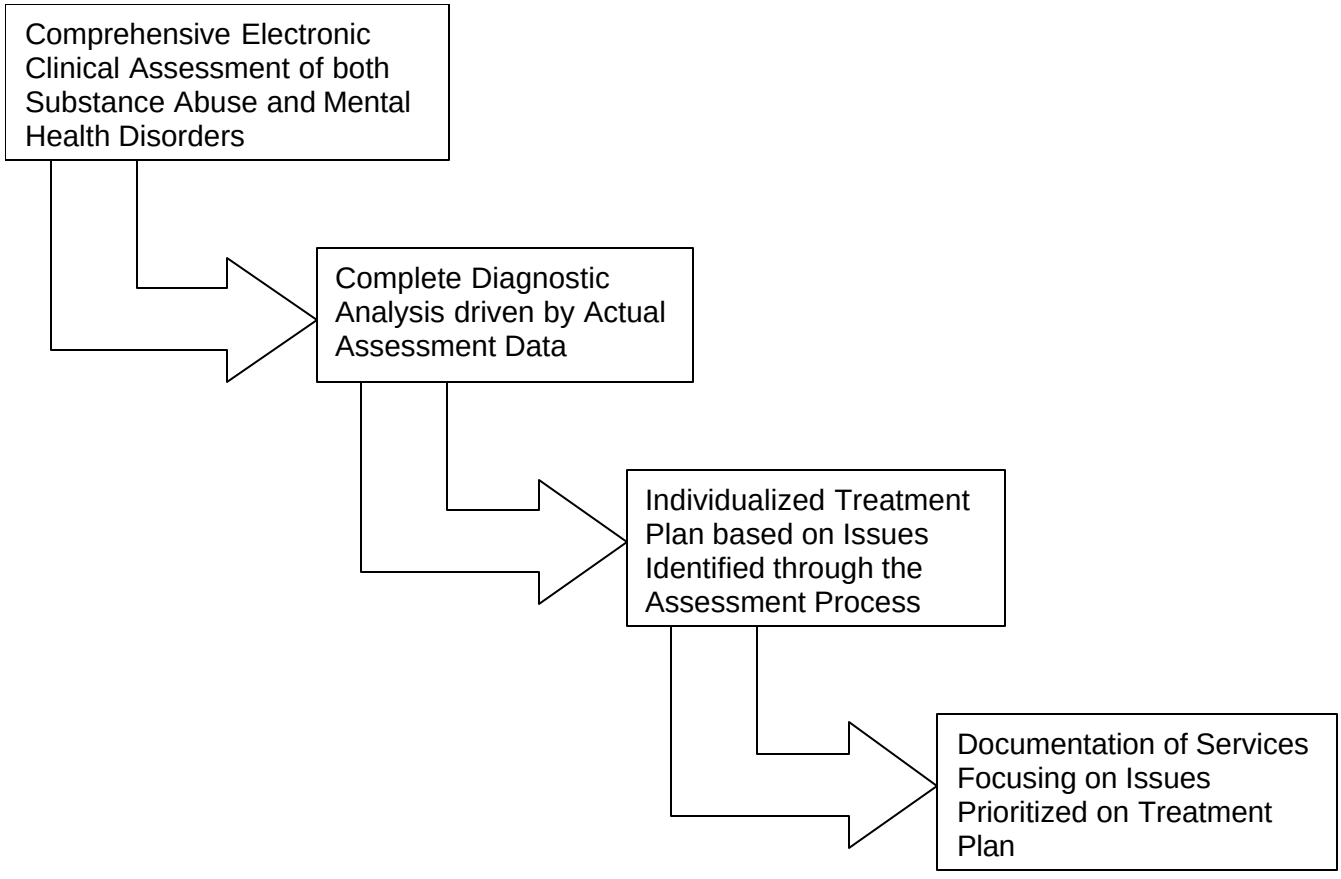
The admissions trends for Wasatch Mental Health reflect a steady increase, which appears to be a natural reflection of the County's growing population. The Center has expanded its satellite operations in American Fork to the north, and Spanish Fork to the south, and anticipates further expansion in conjunction with DCFS and other allied agencies in the future.

Weber Human Services
(Morgan and Weber Counties)

A substance abuse or mental health treatment facility looks much today like it did 10, 15 or even 25 years ago. Walk in the door and you'll probably see a large group room or two, several smaller consultation offices and some administrative space. There has not been much need to modify the overall layout of a typical treatment facility, because there hasn't been much change over the years in how treatment is delivered. However, projects currently underway in local substance abuse and mental health treatment facilities may change all of that.

The future of substance abuse and mental health treatment is not about getting clinicians to use the internet for research or buying fancy computer equipment. It is about a new vision of services that blends best-practice clinical treatment and innovative technologies into a mixture to facilitate high-quality, time-saving, consistent, evidence-based, cost-effective care.

Weber Human Services and Wasatch Mental Health have partnered in the development of a highly technical yet seamless clinical assessment that will incorporate cutting edge best-practice standards with the latest in web-based technology. The assessment will be the first step in collecting and utilizing sound clinical data to help clinicians tailor the ideal treatment program for a particular patient and to help administrators improve the quality of care at their facilities.



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GOVERNANCE AND OVERSIGHT

DSAMH conducts annual contract and program reviews of each Local Authority, and its comprehensive service provider(s). The annual site visits include the following program reviews:

- Adult mental health
- Pediatric mental health
- Adult and youth substance abuse programs
- Justice programs
- Substance abuse prevention
- Governance and oversight components

During fiscal year 2006, 16 Substance Abuse and/or Mental Health Local Authorities and/or their comprehensive service providers (collectively referred to as agency) will be reviewed.

The Governance and Oversight activities have been revised for FY2006. The revisions include the site visit schedule, report format and the overall process related to mailing the combined reports within predetermined time lines. The quality assurance staff assumes the responsibility for scheduling all sight visits and notifying the Local Authorities and service providers one month in advance of the upcoming visit.

The report format that was revised in FY05 was shortened to a three-page succinct summary that includes program strengths, problem areas and corrective action requests when applicable. Additionally, the program managers complete the Bureau of Contract Management report. These reports are submitted to the Quality Assurance (QA) program staff within two weeks of the site visit "audit" week. The QA program staff distributes the Bureau of Contract Management report. The compiled program reports prepared by the program managers are distributed to the appropriate parties within 30 days of the site visit week.

In summary, the previously described process was well received by the Local Authorities and the service providers in FY2005 and continues to be used in FY2006. At the end of the fiscal year, an Executive Summary is traditionally prepared and distributed to the Department of Human Services administration. In this report, the results of the annual site visits are compiled to provide and overview of the fiscal year audit process.

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RESOURCES

List of Abbreviations

ACLSA - Annell-Casey Life Skills Assessment
ACOT - Assertive Community Outreach Teams
ADHD - Attention Deficit Hyperactivity Disorder
ADL - Activities of Daily Living
ASAM - American Society of Addiction Medicine
ASI - Addiction Severity Index
ATOD - Alcohol, Tobacco, and Other Drugs
BPRS - Brief Psychiatric Rating Scale
CARF - Commission on Accreditation of Rehabilitation Facilities
CASI - Children's Addiction Severity Index
CIAO - Collaborative Interventions for Addicted Offenders
CIT - Crisis Intervention Team
CMHC - Community Mental Health Centers
CMS - Center for Medicaid and Medicare Services
COD - Co-Occurring Disorder
CSAP - Center for Substance Abuse Prevention
CSAT - Center for Substance Abuse Treatment
DHHS - Department of Health and Human Services
DHS - Department of Human Services
DOPE - Drug Overdose Prevention and Education
DORA - Drug Offenders Reform Act
DSAMH - Division of Substance Abuse and Mental Health
EQ-I - Emotional Quotient-Intelligence
FACT - Families, Agencies, and Communities Together
FY - Fiscal Year
HCFA - Health Care Finance Administration
IV - Intravenous
JCAHO - Joint Commission on Accreditation of Healthcare Organizations
LMHA - Local Mental Health Authorities
LSAA - Local Substance Abuse Authorities
MH - Mental Health
MHSIP - Mental Health Statistical Improvement Program
MTF - Monitoring the Future
NSDUH - National Survey on Drug Use and Health
OMT - Opioid Maintenance Therapy
OTP - Outpatient Treatment Program
PATS - Prevention Administration Tracking System
PNA - Prevention Needs Assessment Survey
PPC - Patient Placement Criteria
QA - Quality Assurance
RECONNECT - Responsibility, Education, Competency, Opportunity, Networking, Neighborhood, Employment, and Collaboration for Transition
SA - Substance Abuse
SAMHSA - Substance Abuse and Mental Health Services Administration (Federal)
SED - Seriously Emotionally Disturbed
SHARP - Student Health and Risk Prevention
SICA - State Incentive Cooperative Agreement
SIG-E - State Incentive Enhancement Grant
SMI - Serious Mental Illness
SPMI - Seriously and Persistently Mentally Ill
SSDI - Social Security Disability Insurance
TEDS - Treatment Episode Data Set
TIP - Transition to Independence Process
UPAC - Utah Prevention Advisory Council
USH - Utah State Hospital
UT CAN - Utah's Transformation of Child and Adolescent Network
YRBS - Your Risk Behavior Survey
YTS - Youth Tobacco Survey

Contact Information

Single State Authority

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Utah Division of Substance Abuse and Mental Health
120 North 200 West, Suite 209
Salt Lake City, UT 84103
Office: (801) 538-3939
Fax: (801) 538-9892
dsamh.utah.gov

Utah State Hospital:

Dallas Earnshaw, Superintendent
Utah State Hospital
1300 East Center Street
Provo, Utah 84606
Office: (801) 344-4400
Fax: (801) 344-4225
ush.utah.gov

Bear River
Counties: Box Elder, Cache, and Rich

Substance Abuse Provider Agency:
Brock Alder, Director
Bear River Health Department
Substance Abuse Program
655 East 1300 North
Logan, UT 84341
Office: (435) 752-3730

Mental Health Provider Agency:
Mick Pattinson, Director
90 East 200 North
Logan, UT 84321
Office: (435) 752-0750

Central Utah
Counties: Juab, Millard, Piute, Sanpete, Sevier, and Wayne

Substance Abuse and Mental Health Provider Agency:
Doug Ford, Director
Central Utah Counseling Center
255 West Main St.
Mt. Pleasant, UT 84647
Office: (435) 462-2416

Davis County
Counties: Davis

Substance Abuse and Mental Health Provider Agency:
Maureen Womack, M.S., Director
Davis Behavioral Health
291 South 200 West
P.O. Box 689
Farmington, UT 84025
Office: (801) 451-7799

Four Corners
Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider Agency:
Bob Greenberg, M.Ed., LPC, Director
Four Corners Community Behavioral Health
101 West 100 North
P.O. Box 867
Price, UT 84501
Office: (435) 637-7200

Northeastern
Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider Agency:
Ron Perry, Director
Northeastern Counseling Center
1140 West 500 South
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Vernal, UT 84078
Office: (435) 789-6300
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Salt Lake County
Counties: Salt Lake

Substance Abuse Administrative Agency:
Patrick Fleming, MPA, Director
Salt Lake County
Division of Substance Abuse Services
2001 South State Street #S2300
Salt Lake City, UT 84190-2250
Office: (801) 468-2009

Mental Health Provider Agency:
Debra Falvo, MHSA, RN C, President/Executive Director
Valley Mental Health
5965 South 900 East
Salt Lake City, UT 84121
Office: (801) 263-7100

San Juan County
Counties: San Juan

Substance Abuse and Mental Health Provider Agency:
Dan Rogers, MSW, Director
San Juan Counseling Center
356 South Main St.
Blanding, UT 84511
Office: (435) 678-2992

Southwest
Counties: Beaver, Garfield, Iron, Kane, and Washington

Substance Abuse and Mental Health Provider Agency:
Paul Thorpe, MSW, Director
Southwest Center
474 West 200 North, Suite 300
St. George, UT 84770
Office: (435) 634-5600

Summit County
Counties: Summit

Substance Abuse and Mental Health Provider Agency:
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Robert Gorelik, Program Manager
Valley Mental Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157

Tooele County
Counties: Tooele

Substance Abuse and Mental Health Provider Agency:
Debra Falvo, MHSA, RN C, President/Executive Director
Terry Green, Program Manager
Valley Mental Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520

Utah County
Counties: Utah

Substance Abuse Provider Agency:
Richard Nance, LCSW, Director
Utah County Division of Substance Abuse
100 East Center Street, #3300
Provo, UT 84606
Office: (801) 370-8427

Mental Health Provider Agency:
LaMar Eyre, Director
Wasatch Mental Health
750 North 200 West, Suite 300
Provo, UT 84601
Office: (801) 373-4760

Wasatch County
Counties: Wasatch

Substance Abuse and Mental Health Provider Agency:
Dennis Hansen, Director
Heber Valley Counseling
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003

Weber
Counties: Weber and Morgan

Substance Abuse and Mental Health Provider Agency:
Harold Morrill, MSW, Executive Director
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Statewide Provider Network

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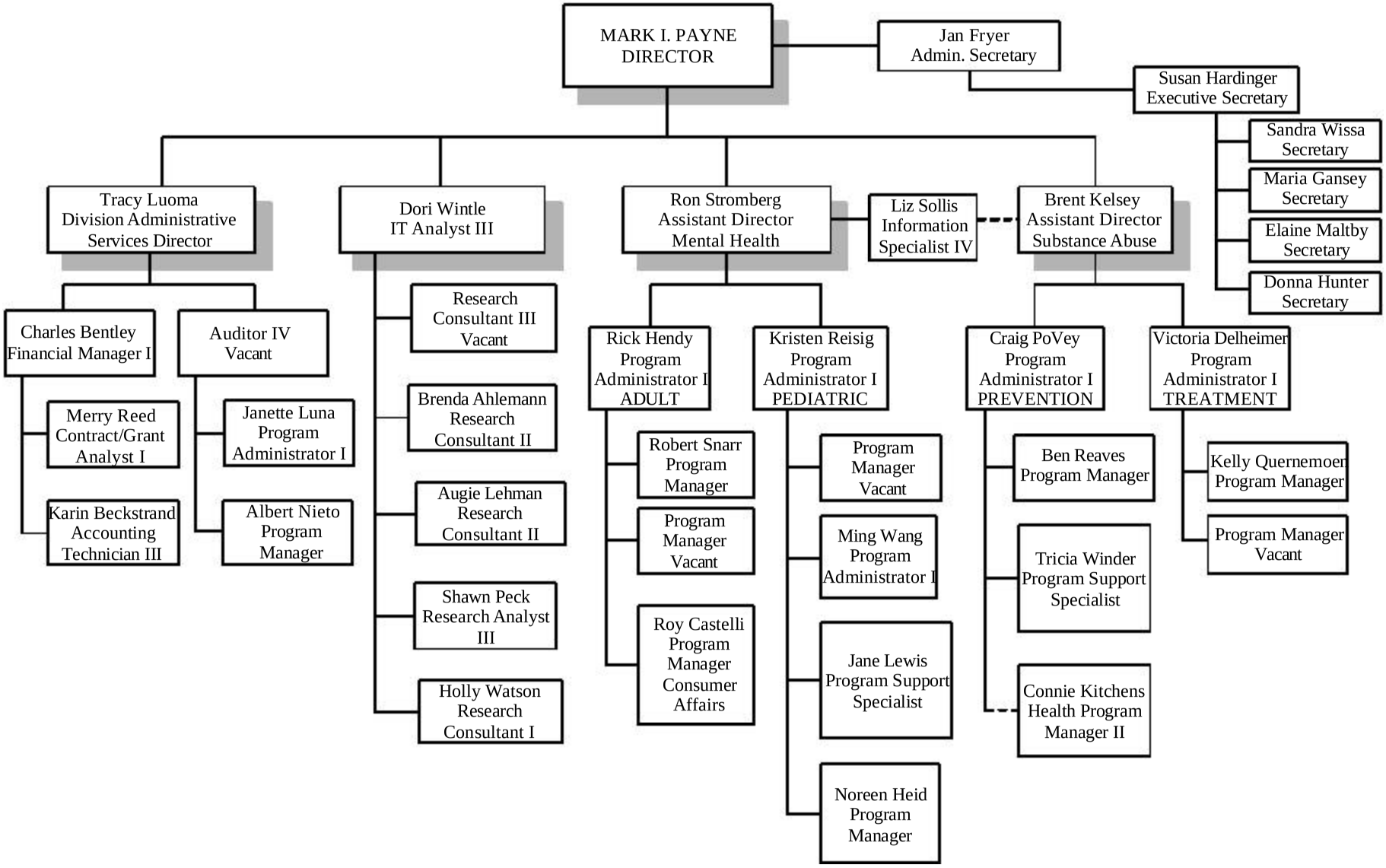
Division of Substance Abuse and Mental Health
January, 2006



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